CareSource H6178,
Dual-Eligible (Dual Subset) Special Needs Plan

Model of Care Score: 83.75%
2-Year Approval **January 1, 2014 to December 31, 2015**

Target Population

CareSource's SNP serves individuals over the age of 21 who are dually eligible for Medicare and Medicaid. The plan's members for which the average age is 58 are generally low income and have limited resources. These members have co-existing medical and behavioral or cognitive conditions as well as multiple co-morbidities associated with chronic illnesses such as chronic obstructive lung disease (COPD), hypertension, diabetes, depression and heart failure. Consequently, many have a high incidence of unmet needs and lack a support system.

Provider Network

CareSource contracts with facilities that provide inpatient, outpatient, rehabilitative, skilled nursing, long term and behavioral healthcare along with laboratory and radiology/imaging services. The SNP's long-term care providers include skilled nursing facilities, residential care facilities and assisted living facilities. CareSource has extended its physician network to providers who specialize in the management of patients who are disabled, elderly, frail and those with complex medical and behavioral health conditions. This includes cardiologists, nephrologists, neurologists, geriatricians, pulmonologists, and behavioral health specialists consisting of drug counselors, psychiatrists and psychologists. CareSource's network also includes: registered nurses, nurse practitioners, nurse managers, nurse educators, pharmacists, physical therapists, occupational therapists, speech pathologists, laboratory specialists and radiology specialists.

The plan has contracts with home and community based providers for skilled and non-skilled services. It also has a partnership with several Community Mental Health Centers (CMHCs) offering mobile crisis services and housing assistance.

Care Management and Coordination

Upon enrollment, members are assigned to a care manager who serves as the "accountable point of contact." A staff person contacts each member and invites them to participate in the care management program. For members who agree to participate, the care manager completes a comprehensive health risk assessment (HRA) in-person, by phone or through web-based media within 90 days of enrollment. It includes a review of the member's medical/behavioral health history, medications, functional, psychosocial, socioeconomic and cognitive needs, caregiver

support, recent changes in condition(s), upcoming medical/behavioral health appointments or procedures and end of life needs. The care manager also completes a functional assessment to identify potential safety concerns or existing disabilities. This assessment identifies barriers to care, access issues, quality concerns, under or overutilization trends and member/caregiver educational needs.

Each member will have an individualized, prioritized care treatment plan (ICP) developed by the interdisciplinary care team (ICT). The ICT develops the ICP based on the member's strengths, needs and preferences, with input from the member, primary care practitioner (PCP), team members and stakeholders deemed pertinent to the member's care. The SNP's ICT has the member at its core, supported by experienced care management/utilization management nurses and other clinical and nonclinical staff who work directly with the member/caregiver and providers to coordinate care. CareSource has trained care managers to administer benefits in collaboration with the ICT, in a way that meets the individual needs of the member.

The ICP treatment process includes: HRA results; prioritized goals and actions with timeframes for completion; a communication plan with the member; a communication plan with the PCP/specialist to ascertain the needs the provider has identified; the identification of ICT members; specific services and benefits needed, including add-on or extended benefits; members' preferences for care; services for members with disabilities; services for those members near the end of life; the identification of providers responsible for delivering care; identification of referrals made to specialists or providers and follow-up; referrals to community/social/recovery agencies including assisting members with contacting the agency; a review of the new or updated treatment plan with member, family/caregiver and the PCP/specialist; contingency plans for changes in condition or changes in caregiver availability/ability; a plan for effective care transitions; continuous review and revision of the treatment plan, which includes follow-up contact along with the identification of gaps between recommended care and care provided; and the provision to supply feedback to a provider on member adherence with a treatment plan.

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.CareSource.com