Care Wisconsin Health Plan Inc., H7475
Dual Eligible Subset Medicare Zero Cost Sharing Special Needs Plan

Model of Care Score: 86.88%
3-Year Approval **January 1, 2012 to December 31, 2014**

Target Population

Care Wisconsin Partnership (CWP) is a Dual-Eligible Special Needs Plan (D-SNP) that fully integrates Medicare, Medicaid and long-term care services through a Medicaid contract with Wisconsin Department of Health Services. The target population includes members who are at least 18 years old, frail elders, adults with physical disabilities, Alzheimer's disease, a terminal illness or developmental disabilities. CWP serves residents in Columbia, Dodge, Jefferson and Sauk Counties.

Provider Network

CWP's policy is to develop and maintain sufficient provider resources based on enrollment, growth and utilization, taking into account member characteristics and health and long-term care needs. CWP ensures members have access to essential services through provision of direct care by a nurse practitioner (primary care), registered nurses (nursing care) and Masters' prepared social workers (mental health and social services); additional services are coordinated with community primary care physicians (PCP), physician specialists, long-term care service providers as well as other providers.

Care Management and Coordination

The Department of Health Services (DHS) requires CWHP to develop a member centered plan (ICP) every six months for each member. The ICP is a way to assure the member, family, caregivers and interdisciplinary care team (ICT) are in agreement with the priority goals and outcomes that members want to be working towards achieving over the next six months. The ICP is developed by interviewing the member to determine their individual preferences, outcomes and goals. This information is combined with the assessments completed by each member of the ICT, which includes a full exploration of bio-psycho-social needs, areas of risk and member support networks to assist them in achieving their outcomes and goals. Information from other providers may be incorporated into the ICP as appropriate.

The ICT includes: a nurse practitioner (NP), a registered nurse (RN), a Masters prepared social worker/counselor and a service coordinator. The ICT staff is responsible for working with the

member to provide/coordinate long term care and acute and primary services. Additional service providers commonly participate in a member's ICT according to a member's identified needs. Examples of additional service providers include: a primary care physician (PCP), mental health providers (psychiatrist or counselor), restorative therapists (physical therapists or occupational therapists), the Care Wisconsin medical director, pharmacist and the family or caregiver.

Members of the ICT complete a set of assessments in order to appropriately identify medical and social needs while taking into account member goals and preferences. The advanced practice NP takes a member's history and physical (H&P) within four weeks of enrollment and annually thereafter. The NP also performs a six month review, which is a face-to-face visit with the member. The RN completes an initial health risk assessment (HRA) with the member within 10 business days of enrollment. The RN is also responsible for quarterly face-to-face nursing assessments. Social services staff conduct initial enrollment contact, an initial psychosocial assessment and an annual psychosocial assessment.

The ICT analyzes the findings from all of the assessments and shares the results with the member during the creation of the ICP. When the ICP is finalized it is signed by the member and any other supports the member wishes. The assessments and plans are all documented in a secure electronic health record that is accessible by the entire ICT.

It is CWHP's policy that the member is an active participant on the ICT and care planning process. Care planning is conducted face to face with the member within 90 days of enrollment, every 6 months thereafter, and as needed per changes in condition. Care planning may also involve joint care conferences with ICT staff, members, providers and other caregivers.

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.carewisc.org/