**H9886 HMO Missouri Inc.**
**Dual Eligible Subset – Zero Cost Sharing Special Needs Plan**

**Model of Care Score: 86.67%**
**3-Year Approval** **January 1, 2015 – December 31, 2017**

---

## Target Population

HMO Missouri Inc. (HMOM) serves individuals who are eligible for both Medicare and Medicaid in ten states. Of the 36,000 members currently enrolled in the plan, 53 percent of members are under 65 years old, 69 percent are female and 70 percent speak English as their primary language. The majority of members are White (37.16 percent) or Black (33.51 percent).

About half of members have conditions or have received benefits that qualify them as having a disability. The most prevalent conditions among members include diabetes, chronic obstructive pulmonary disease (COPD), psychiatric (depression or bipolar) conditions, renal and pulmonary disorders.

Dual-eligible members face major challenges such as a lack of financial resources, homelessness or unstable home environment, access to care issues due to transportation barriers or living in rural areas, variations in education and poor health literacy, comorbid conditions, communication difficulties including language, hearing and cognitive issues and caregiver difficulties. Furthermore, these members must navigate Medicare and Medicaid systems which are especially challenging for those with more complex needs and can lead to fragmented, costly care and potentially, poorer health outcomes.

## Provider Network

The HMOM network consists solely of contracted providers who provide direct patient care services. These providers include geriatricians, physical medicine physicians, behavioral health (mental health and substance abuse) providers and facilities, skilled nursing facilities, ancillary providers and facilities, cardiologists, endocrinologists, diabetic educators, dialysis centers, federally qualified health centers, rural health care centers, social workers and nursing professionals.

## Care Coordination and Management

Within 90 days of enrollment, members are asked to complete a comprehensive health risk assessment tool (HRA) telephonically, face-to-face (in-home or in a facility), by mail or by vendor. The HRA assesses members' physical and mental health, functional, cognitive and psychosocial status. The case management system houses the HRA results as well as detailed clinical information on each member. Reassessments are performed annually and after a member experiences a significant change in health status or a transition.

The case manager (CM) develops the individualized care plan (ICP) using information gathered through the assessment process, including a review of the relevant evidence-based clinical guidelines. The ICP includes prioritized short and long-term goals that consider the member's and caregiver's self-management goals, personal healthcare preferences, and desired level of involvement in the case management plan. Additionally, the ICP includes services designed to meet the member's needs, and the role of the member's caregiver. Once the ICP is completed in the case management system, it is available for review and distribution electronically or in hard copy (by email, fax or mail) to members of the interdisciplinary care team (ICT) and external providers. The ICT reviews the ICP annually, at a minimum, or whenever the member experiences a change in condition or status, and when ICP goals are achieved or require revision.

At its core, the ICT includes the member, CM and primary care provider (PCP). Members with more complex care needs have additional members in their ICT to reflect the array of services and programs that they utilize. The ICT develops the ICP, manages transitions and addresses gaps in care and determines the most appropriate care path for each member. The CM works closely with the PCP via phone, fax, and/or in person to coordinate the member's care with other disciplines and providers. The ICT meetings may be held telephonically, electronically or in person.

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.anthem.com\medicare\