SNP Alliance Best Practices

October 2013

CareMore: Best Practices in Chronic Illness Care

About CareMore

Founded in 1993, CareMore specializes in providing a complete, proactive health care experience to people eligible for Medicare. From its origins as a medical group caring for Medicare beneficiaries, CareMore evolved into CareMore Health Plan, Inc. in 2001, when it obtained a CMS contract. The CareMore name embodies the philosophy that inspired a proactive model of care with a caring touch and focus on wellness. CareMore's mission is to:

- Provide focused and innovative health care approaches to the complex problems of aging;
- Serve members by prolonging active and independent life;
- Serve caregivers and family members by providing support, education, and access to services; and
- Protect precious financial resources of members and the Medicare Program through innovative methods of managing chronic disease, frailty, and end of life.

CareMore has historically offered a variety of Medicare Advantage products designed to meet the needs of Medicare beneficiaries. The products include MA-PD HMOs alongside a range of Special Needs Plans (SNPs) all of which are coupled with enhanced prescription drug coverage. CareMore offered its first SNP plans in 2007 in Los Angeles County and now offers 29 plans across its service area. Of the 29 plans, 25 are Special Needs Plans for individuals with chronic health conditions (C-SNP). C-SNP plans are offered by CareMore Health Plan, CareMore Health Plan of Arizona, and CareMore Health Plan of Nevada. Offerings include:

CAREMORE BREATHE *for individuals with Lung Disease*
CAREMORE ESRD *for individuals with End Stage Renal Disease*
CAREMORE HEART *for individuals with Cardiovascular Disease and Congestive Heart Failure*
CAREMORE DIABETES *for individuals with Diabetes Mellitus*

There are over 73,000 members in the existing CareMore plans with approximately 43% enrolled in a SNP plan. Unique to its plans is CareMore's model of care. Designed by physicians to address the unique needs of the frail and elderly, the model of care is focused on managing chronic diseases, such as diabetes, heart, lung, and end stage renal disease (ESRD) that, if left unmanaged, can result in decreasing functionality and ultimately higher health care costs. The model is best described as a hybrid health care system and health plan. Primary Care Physicians (PCP) are contracted to provide basic health care needs. When a member's care intensifies due to a chronic condition, CareMore clinical staff take on the management of highly complex patients in partnership with the member's PCP.

Unique Plans, Benefits and Care Programs

CareMore's traditional MA-PD product offers beneficiaries added value by featuring a $0 monthly premium plan in most markets and affordable cost sharing on medical services and prescription drugs. The SNP plans offered are available to Medicare beneficiaries with dual eligibility status, institutional status, or one of the following qualifying chronic conditions: diabetes, chronic lung disorders, chronic heart failure and cardiovascular disorders, or end stage renal disease (ESRD). SNP products include unique benefits and services to address the needs of the population being served. These include comprehensive disease management programs, transportation, and specialized exercise programs. Our Dual Eligible SNP has no cost sharing on Medicare-covered benefits, enhanced prescription drug coverage, dental and vision benefits. CareMore also has an Institutional SNP product, which brings health care services to beneficiaries who reside in community, assisted living, or long-term care facilities. These plans include $0 copayments on the majority of benefits and a care model that addresses the unique needs of institutional frail beneficiaries.

Benefits are aligned with our model of care and the health needs of a spectrum of Medicare beneficiaries. The majority of plans have $0 copayments for preventative and primary care, low cost skilled nursing services, transportation, exercise and strength training, electronic health monitoring, access to low-cost prescription drugs, and low or no monthly premiums — these benefit strategies are used to reduce barriers to care for our Medicare beneficiaries, which have resulted in positive clinical outcomes.

In addition, Special Need Plans (SNPs) provide enrollees coordinated care options that focus on the unique needs of this population. To support the model of care, benefits are structured to reduce financial barriers to needed care. In addition, CareMore's model provides comprehensive assessments and various heath related programs to help address the overall needs.

The CareMore Model

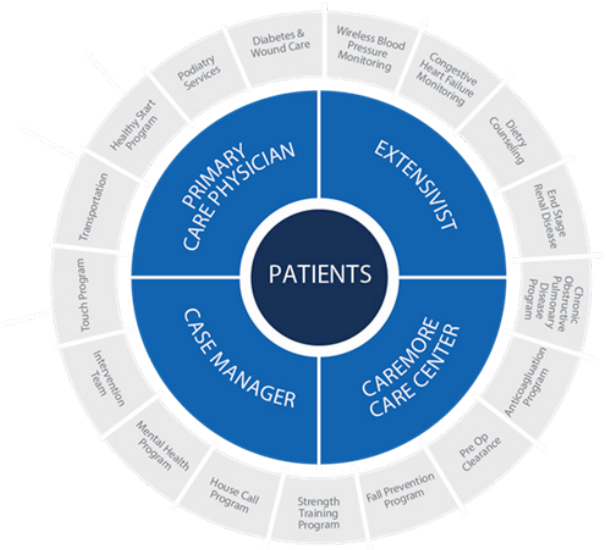
CareMore's approach to care delivery is uniquely suited to the specialized needs of patients with chronic conditions. Many of these at-risk patients have struggled in managing multiple chronic illnesses, have functional impairments and are at significantly higher risk of hospitalization and nursing home placement. Moreover, they typically have a difficult time advocating for their own needs in a complicated health care system, which exacerbates their risk of deterioration. By providing coordinated medical care and supportive services, CareMore has shown that it is possible to improve patient outcomes and satisfaction while reducing costs.

Diabetes	End Stage Renal Disease	Congestive Heart Failure
		
Result	**Result**	**Result**
7.07 average HbA1c for those attending our diabetic clinic	**50% reduction in hospital admission rate in 5 months**	**56% reduction in hospital admission rate in 3 months**

In the CareMore model, teams of non-physician health care providers, based in a CareMore Care Center, supplement primary care medical practices with hands-on disease and frailty management. Within these Care Centers, a detailed array of services are provided, which are generally too complex or costly to be provided within the primary care office. The CareMore Care Center becomes a type of "medical home" for patients with chronic conditions, where care is both delivered and coordinated, and where questions are answered. A variety of support services are provided to remove barriers that lead to patient non-compliance with care programs. These services include transportation, remote monitoring, home visits and social support services.

To support the model, CareMore employs clinicians to deliver care called "extensivists" (internists by training) who manage the complex health conditions and co-morbidities of members. Unlike traditional network managed care plans, the CareMore model uses an Extensivist/Internist to directly manage a member's care, with routine communication to the PCP. The health plan also employs other specialists and clinicians including pulmonologists, cardiologists, dermatologists, house call physicians, nutritionists, and medical assistants. Specialized Nurse Practitioners (NP) provide patient care and education as well as coordinate the many services and providers that members may need to address their co-morbidities. NPs are also used to provide care to members residing in nursing homes, assisted living facilities, or other long-term care settings. This model of care allows the plan to meet the needs of older adults as they age including end of life care. Some programs include:

- Shape Up. Levels Down™ Exercise and Strength Training
- Home Care
- Mental Health Program
- Social Services
- Podiatry
- Hospice
- Palliative Care
- Wellness Programs
- Transportation
- Diabetes-specific services
- ESRD-specific services
- COPD-specific services
- Hypertension and CHF-specific services



The CareMore Care Centers focus on proactive, integrated health care to meet the unique needs of Medicare beneficiaries, including diabetic education, wound management, a foot care program, nutritional counseling, and many other social, clinical, and para-clinical services for a high-risk frail population. The centers provide comprehensive physical examinations, called "Healthy Start" in the first year of a member's enrollment, as well as an annual health assessment called "Healthy Journey" for C-SNP members. There are currently forty-one (41) Care Centers and two (2) dedicated free-standing Mental Health Centers. As membership grows, centers are added to ensure member access and the ability to replicate the care model and outcomes. The addition of the Care Center to the continuum of health care delivery services, along with CareMore employed extensivists and case managers, allows CareMore to more effectively meet the increased demands of the chronically ill. This is not simply a better way to work with or "through" traditional health care providers, but a fundamentally new method of delivering needed services which has demonstrated superior health outcomes.