Amerigroup, H1894, H5817, H7200, H6181, H3240, H5746
Dual Eligible (Subset - Medicare Zero Cost-sharing) Special Needs Plan
(WellPoint)

Model of Care Score: 92.50%
3-Year **Approval January 1, 2014 – December 31, 2016**

Target Population

The plan targets members that have Medicare and Medicaid. There is a large minority of members enrolled in this plan that are under 65 years of age (43 percent), who tend to also be disabled. 45 percent of members report having four or more chronic conditions, with diabetes, cardiovascular (heart), chronic obstructive pulmonary disease (COPD), mental health and renal (kidney) conditions the most prevalent. English is the primary language with Spanish and Chinese (in New York) being the next most prevalent languages spoken.

Provider Network

The provider network consists of contracted providers who provide direct patient care services. The network includes primary care and specialists trained to manage the most prevalent chronic conditions in the target population such as geriatricians, behavioral and mental health providers, cardiologists, endocrinologists, dialysis centers, skilled nursing facilities, social workers, nursing professionals and home health. The network has representation of culturally diverse backgrounds to manage and coordinate care for the target population. In addition, the provider network consists of services such as access to assistive devices and other medical and non-medical equipment, transportation to medical visits and home visits through home health agencies to provide home safety assessments for members at high risk for falls.

The plan has an "open access" model. All members choose a primary care physician (PCP) and are encouraged to coordinate care through their PCP, but are not required to obtain a referral prior to seeking care from a participating provider or specialist. Members and providers are required to obtain authorizations prior to receiving certain services. The PCP is responsible for coordinating the member's care and ensuring the appropriate specialty care is arranged.

Care Management and Care Coordination

The plan uses a standard, comprehensive health risk assessment (HRA) tool designed to assess physical, mental, functional, cognitive and psychosocial health and status. Members receive the HRA upon enrollment and annually thereafter. The tool identifies immediate needs and serves as a referral to other programs and benefits, such as complex case management. The assessment is usually conducted within 30 days after enrollment by a nurse via telephone with the member. Results are reviewed by a nurse or social worker that serves as a case manager. The case managers are responsible for coordinating care, assisting members in accessing community-based resources, providing condition-specific education and other interventions to assist members.

Case managers work with members and providers to design an individualized care plan (ICP) based on identified problems, goals and cultural preferences of the member. Standard components of the ICP include coordination of care, care transition, preventive care, and disease specific education based on individual results, short and long-term goals, interventions and outcomes. Case managers encourage members to take an active role in developing the care plan, particularly goals and interventions.

The interdisciplinary care team (ICT) is a multi-member team that may consist of medical, mental/behavioral and social services experts and other practitioners as determined by the member's needs. The full composition of the ICT is determined by the level of risk and need for each member, but always includes the PCP. The ICT is responsible for analyzing and incorporating results from the HRA, developing and updating the ICP and managing the physical, functional, cognitive and psychosocial needs of the members and communicating and coordinating the care plan. The case manager is the main person responsible for coordination within the ICT and works closely with the member's PCP to determine appropriate services and interventions. For members determined to be at high risk or have more complex care coordination needs, the ICT follows the plan's "Intensive Case Management" procedures. This includes weekly, or as determined, team meetings with members either by conference call or in-person to discuss member needs and progress toward goals in the ICP. These teams generally include case managers, medical directors, pharmacy, behavioral health and social work providers as well as the PCP.

For more information about this health plan refer to the Special Needs Plan's website at: http://www.wellpoint.com/.