Peoples Health Secure Health and Peoples Health Secure Choice, H1961
Dual Eligible (All Duals) Special Needs Plans

Model of Care Score: 90.63%
3-Year Approval **January 1, 2013 – December 31, 2015**

Target Population

Peoples Health Secure Health's and Peoples Health Secure Choice's target populations include members who qualify for Medicaid on the basis of poverty or disability and tend to have more complicated needs. The plan incorporates the needs of vulnerable SNP sub-populations into the Model of Care; these sub-populations include members who are frail, disabled, have chronic illnesses or are near the end of life.

Provider Network

The plan contracts with primary care physicians (PCPs) and all Medicare required specialists. Specialists include physicians with expertise in chronic and identified co-morbid conditions, rehabilitation/restorative specialists, mental health and substance abuse specialists, wound care and oral health specialists. The contracted providers with the most highly utilized disciplines are PCPs, cardiologists, endocrinologists, ophthalmologists and pulmonologists. Additionally, the plan contracts with a number of acute care, long-term care, skilled nursing, rehabilitation, and urgent care facilities. It also contracts with diagnostic, imaging, dialysis, durable medical equipment, laboratory and home health providers. A regional administrator who is a registered nurse (RN) oversees each regional interdisciplinary care team (ICT) and is responsible for the overall coordination of care of the members assigned to the team and managed by a Field Supervisor, who is an RN.

Care Management and Coordination

The SNP-specific health risk assessment (HRA) tool addresses the medical, psychosocial, cognitive and functional needs of the member. Peoples Health contracts with a vendor, National Research Corporation, to whom Peoples Health has delegated the responsibility to administer and collect the HRAs. The initial paper-based HRA is mailed to the member within 30 days from the member's effective date with the plan and annually thereafter. A care coordinator (case management nurse (RN), chronic care nurse (RN), or licensed social worker (LCSW or LCSW-eligible)) reviews the stratified results from the agency and creates plans, goals and interventions when applicable in the care management system. During the ICT review team meeting, the team reviews each member's health assessment results, medical history and individualized care plan (ICP) to determine the appropriateness of problems, goals and interventions.

The care coordinator, who is a member of the overall ICT develops the ICP for the member along with the member/caregiver and providers when necessary. The ICP contains a listing of member-specific medical and health related problems, short and/or long term goals and

interventions needed to meet the goals in order to obtain the best possible health outcomes. The care coordinator reviews the ICP with the member/and or caregiver face-to- face or by phone and may update the ICP based on the member's or caregiver's feedback and healthcare preferences. Together, the member and care coordinator create a time frame for reevaluation of their goals if necessary; otherwise, the care coordinator will reevaluate the ICP annually thereafter. The ICP is available to the ICT through the plan's care management documentation and authorization system and/or the plan's secured, web-based, comprehensive portal, where it is stored.

The plan selects the members of the ICT based on their expertise in the social, chronic care, and disease management aspects of their individual disciplines in order to address the unique needs of the dual-eligible population. The ICT members/contributors may include social workers, case managers, chronic care specialists, nurse practitioners, pharmacists, PCPs, nutritionists, preventative health specialists, mental health experts, family members/caregivers and the medical director. The care coordinators will communicate the decisions of the ICT and revisions of the ICP to the member and his/her family through face-to-face consultation or by phone.

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 member needs.

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