H3272 Riverside Advantage, Inc.
Full Benefit Dual Special Needs Plan

Model of Care Score: 88.33%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Riverside Advantage, Inc. (RA) serves members who (1) have full Medicaid coverage or full Medicaid coverage, (2) reside in the one of the following counties in Maryland: Anne Arundel, Baltimore City, Baltimore, Caroline, Carroll, Cecil, Dorchester, Harford, Howard, Kent, Montgomery, Queen Anne's, Somerset, Talbot, Wicomico or Worcester; and (3) live in a community assessed as nursing home certifiable or non-nursing home certifiable.

Seventy-five percent of the dual-eligible population in Maryland is female, 55 percent are over the age of 65 with 49 percent identifying as Caucasian and 41 percent as African American. Dual-eligibles are two-and-a-half times more likely than Medicare-only beneficiaries to have five or more chronic conditions. There are higher rates of heart disease, diabetes, depression, heart failure and respiratory disease, including chronic obstructive pulmonary disease and arthritis, mental illness and Alzheimer's disease among the dual-eligible population. In addition, there are higher rates of modifiable risk factors including smoking, substance use disorders and obesity.

Higher rates of chronic conditions, mental illness and impaired functional abilities place dual-eligibles at greater risk for nursing home admissions as well as increased utilization of emergency room, inpatient stays and readmissions. Additionally, since many dual-eligibles are living at, or near poverty levels, they are more likely to be home bound, socially isolated, have poor nutrition, require more social supports and be at risk for an institutional level of care.

Provider Network

The facilities included in the network are: acute care facilities, labs, imaging, specialty clinics, long-term care facilities, pharmacies, rehab centers, home health care, dialysis clinics and nursing facilities. In order to adequately meet the special needs of these dual-eligibles, the plan's provider network includes geriatricians, pain specialists, nursing professionals, mental health specialists, allied health professionals and medical specialists such as cardiologists, endocrinologists, pulmonologists and rheumatologists. Each member chooses or is assigned a primary care physician (PCP) who is responsible for overseeing and coordinating the member's care with specialists.

Care Management and Coordination

The plan's health risk assessment tool (HRAT) focuses on multiple domains including medical, behavioral health, psychosocial, functional, cognitive and nutritional needs. In addition, the HRAT includes four screening tools to further assess identified issues such as sleep, pain, mental health and nutrition. The initial HRAT can be conducted telephonically or in person within 90 days of enrollment. HRAT reassessments will occur within 12 months of the initial or last assessment. If a member's condition changes or deemed at higher risk, reassessment occurs sooner.

Upon receipt of the completed HRAT, the case manager (CM) creates an individualized treatment plan (ICP), in collaboration with the member and any other identified providers. At a minimum, the ICP includes: member's diagnoses and health status, functional status, pharmacy profile, resource utilization (emergency department, outpatient and inpatient), behavioral health issues (if applicable), social support, risk category, and when applicable, the reason or need for interdisciplinary care team (ICT) evaluation. Additionally, the ICP includes a list of prioritized goals and objectives and an action plan on how to achieve progress towards the goals. The ICP is reviewed annually, at a minimum, and modified on a regular basis as the member's health care needs change.

The ICT is responsible for managing the member's medical, cognitive, psychosocial and functional needs. Its composition includes: the CM, PCP, medical director, clinical pharmacist, behavioral health provider, specialist(s), discharge planners, utilization management staff and other ancillary providers that coordinate the member's care according to the identified needs. The ICT meets on a bi-weekly basis or sooner based on members' needs, their deliverables and timelines for completion.

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: http://www.myriversidehealth.com/About-Us