HealthAmerica Pennsylvania, Inc., H3959
Dual Eligible (All Dual) Special Needs Plan

Model of Care Score: 96.88%
3-Year Approval **January 1, 2013 to December 31, 2015**

Target Population

HealthAmerica's Special Needs Plan (SNP) focuses on the dual eligible population and identifies members who are at risk for chronic health issues and socio-economic challenges. Currently, 25.86% of the population are over the age of 80 and 59% of the population are female. The highest volumes of medical conditions include hypertension, high cholesterol, osteoporosis, chronic obstructive pulmonary disease (COPD) and diabetes. The membership is spread throughout 44 counties of Pennsylvania, but over 50% of the membership are in four counties.

Provider Network

HealthAmerica contracts with a variety of providers to meet the needs of the SNP population. All major specialties and services are represented in the SNP's panel of participating providers, such as acute care facilities equipped to manage the dual eligible members who have multiple, severe, chronic conditions, long term care needs or members who may have at least one cognitive or mental impairment. The network is comprised of hospitals and medical centers, psychiatric facilities, laboratories, long term care and skilled nursing facilities, pharmacies, radiological and imaging facilities, rehabilitative facilities, primary care providers (PCPs), home health service providers, behavioral health specialists, dentists/oral health specialists, dialysis facilities, nursing professionals and allied health professionals. Additional services include specialized clinical expertise and medical specialists.

The PCP is the gatekeeper and is responsible for identifying the needs of the member. Additionally, the PCP works in tandem with the case manager who functions as the central coordinator of care across all settings and providers.

Care Coordination

The health risk assessment (HRA) tool was designed to identify key SNP member care needs, including medical, psychosocial, functional and cognitive needs. It was developed using the interdisciplinary care team (ICT) oversight with input from the provider and member community, and it utilizes tree logic to integrate the specialized needs of its members. The HRA is conducted within 30 days of member enrollment and annually via face-to-face interview, by telephone or paper-based. A reassessment is also conducted with any flagged health changes identified by claims data mining, the clinical provider or member self-reported information.

The HRA tool is pre-populated with provider network claims and encounter information including medical, pharmacy, and laboratory and facility data. The HRA tools allows for validation of pre-populated data while collecting member reported information. As different

sections of the HRA tool are completed, the tool uniquely stratifies the member using the combined data elements.

Using the results from the HRA, member's medical history, healthcare preferences and pharmaceutical profile, the nurse case manager, in conjunction with the member, initiates the care plan, assesses the completed HRA tool and works with the ICT to develop the individualized care plan (ICP). Each member's ICP identifies goals that reflect that his or her unique needs are realistic and measurable, include a timeframe for achievement as appropriate, identifies services and care to meet member's care goals and connects the member/caregiver with add-on benefits and services. It also includes any barriers to achieving the goals. Frequency of care plan review is determined by the member's needs, but at a minimum twice yearly and with any significant changes in the member's health status.

HealthAmerica assigns an ICT to each member and the composition of the ICT is determined by the needs of the member. The team consists minimally of a physician (usually the PCP), social services specialist, pharmacist, nurse case/disease manager and behavioral health services specialist to assure that the medical, functional, cognitive and psychosocial needs of the member are considered in care planning. Other disciplines will be added as appropriate to meet the member's needs. These include specialty providers, nurse practitioners, restorative health specialists, dieticians, nutritionists, pastoral care, palliative care and home care as needed. The ICT will meet on a monthly basis.

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: http://pa.chcadvantra.com