Advantage by Superior HealthPlan, H5294
Dual Eligible (Full Benefit) Special Needs Plan

Model of Care Score: 86.88%
3-Year Approval **January 1, 2013 to December 31, 2015**

Target Population

Superior HealthPlan enrolls beneficiaries that are full benefit dual-eligible, Qualified Medicare Beneficiary Plus (QMB+), and Specified Low-Income Medicare Beneficiary Plus (SLMB+) as well as Star+Plus populations who are aged, blind and disabled. The target population consists of younger Medicare beneficiaries, with an average age of 57, and more females than males.

Provider Network

Superior provides enrollees access to a wide range of credentialed and contracted providers that include: physicians; nurse practitioners; physician assistants; dietitians; acute care facilities such as hospitals, emergency departments, urgent care centers and some long-term care hospitals; laboratories; skilled nursing facilities; federally qualified healthcare centers (FQHCs); rural healthcare centers (RHCs); pharmacies, radiography facilities; rehabilitative facilities; dialysis centers; outpatient surgery centers; hospices; home health agencies; infusion centers; durable medical equipment suppliers; behavioral health practitioners; oral/dental specialists and vision specialists. Beneficiaries also have access to providers who offer value added services, such as disease management programs and specialists that focus on chronic conditions and disease states. In rare instances where in-network services are not available within the Superior network, enrollees are granted access to out-of-network providers, coordinated by the interdisciplinary care team (ICT).

Care Management and Coordination

The health risk assessment (HRA), a standardized assessment tool created by Superior, is designed to identify the needs of the most vulnerable members by evaluating medical, psychological, functional and cognitive needs. HRAs are conducted by service coordinators within 90 days of the member's enrollment, usually by phone. In-person assessments are done when warranted. Assessments are then conducted annually or more frequently if needed based on the members' health status. Details of the HRA are provided to the ICT to develop the individualized care plan (ICP).

The service coordinator is the primary person responsible for developing the ICP for each member based on HRA results. The ICT works with the enrollee (or enrollee's designated representative), the member's primary care physician (PCP), and other key specialists when feasible to develop the care plan specific to the needs of the individual and designed to mitigate

any risks identified. The ICP includes a set of attainable goals and measurable outcomes including, preventive health services delivered to the enrollee, preferences for care, chronic conditions and special needs of the enrollees. The ICP is intended to increase self-management, improve mobility and functional status, reduce any pain and create an improved satisfaction with health status and health care services that result in improved quality of life perception. The ICT communicates any changes in the ICP to the beneficiary, other members of the ICT, and providers as needed via email, mail, and fax and documents this in the clinical documentation system

The care management team, known as the ICT, reviews the gathered information and begins to build a complete care management ICP within 30 days of the assessment and identification of the member as appropriate for care management. The ICT is generally comprised of multidisciplinary employed clinical and nonclinical staff. The non-medical personnel perform non-clinical based health service coordination and clerical functions, and licensed professional staff focus on the more complex and clinically based service coordination needs. The ICT also includes a PCP and specialty care providers pertinent to the member's needs that may include, a nurse practitioner, mid-level provider, social worker, registered nurse, occupational/speech/ physical therapist, dietician, pharmacist, health educator, disease manager, behavioral/mental health specialist, community resources specialist, dentist, pastoral services, and others.

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://advantage.superiorhealthplan.com/