Arcadian Health Plan Inc., H5619
Dual Eligible Subset (Medicare Zero Cost Sharing) Special Needs Plan

Model of Care Score: 90.00%
3-Year Approval **January 1, 2012 to December 31, 2014**

Target Population
Arcadian Health Plan (AHP) offers Dual Eligible Special Needs Plans (D-SNP) serving QMB individuals living in the state of Maine. Targeted members include those who are dually eligible for Medicare and Medicaid, living in underserved areas with limited access to public transportation and other support services; experience a higher rate of racial and cultural disparity; have a higher number of co-morbidities and are limited by a lower level of education. The prevalence of many serious health conditions, such as cognitive or mental impairments, depression and diabetes is significantly higher for duals than for non-duals.

Provider Network
AHP contracts with a full network of board certified physicians, institutional and ancillary providers as required by CMS. AHP is committed to developing and maintaining a comprehensive provider network that meets the medical needs of members. An online provider directory and hard copy directory is available. The providers used by AHP meet the health care needs of our targeted D-SNP membership, all providers serve Medicaid members and therefore provide full access to SNP members. In most service areas AHP specifically contracts with Federally Qualified Health Centers (FQHC) provider organizations that have specialized expertise in providing healthcare services to Medicaid members. AHP contracts with behavioral health specialists, physical therapists, occupational and speech therapists, laboratories and radiology providers for all service areas.

Care Management and Coordination
AHP conducts an initial health risk assessment (HRA) for each member within 90 days of enrollment and annually, within one year of the previous assessment. The HRA results identify member's needs and enable stratification of identified risk. Members identified as being at risk undergo a more intensive assessment that provides a thorough review of 14 key domains representing the majority of problem areas that most dramatically impact the quality of life of dual eligible individuals. After the initial stratification and placement into either Level 1, 2 or 3, members will be assessed on an ongoing bases and their placement into a level will be modified as indicated. The HRA results are shared with the primary care provider (PCP), case manager (CM), interdisciplinary care team (ICT) and other health care providers as appropriate. The risk assessment is used by the CM to develop the member's individual care plan (ICP). The ICP includes the following essential elements: problems/concerns category and status, as a result of the HRA; goals; action steps; service and benefit suggestions and member/family preferences for care. At least annually, the ICP is reviewed and revised based on and feedback from the member, the member's caregiver, PCP, ICT and other providers and community resources personnel. AHP uses an interdisciplinary care team (ICT) to develop ICPs and manage member health care. It is the responsibility of the ICT to assure timely and appropriate delivery of services, providers' use of clinical practice guidelines developed by professional associations, timely follow-up to avoid lapses in services or health care when there is transition across settings or providers and conducts chart and/or pharmacy reviews. The ICT also analyzes and incorporates the results of the initial and annual health risk assessment into the ICP,

collaborates to develop and update an ICP for each beneficiary; manages the medical, cognitive, psychosocial and functional needs of beneficiaries through the initial and annual health assessments; communicates to coordinate care plan with all key stakeholders including the provider, beneficiary, family and health plan, as needed; maintains a web based meeting interface and maintains a mechanism for resolution of beneficiary complaints and grievance.

The composition and frequency of the member's ICT is based on the member's health needs. For example, a Level 1 ICT includes: the member; the member's caregiver, PCP, CM, case coordinator, behavioral health expert and pharmacist. A Level 3 ICT includes: the member; the member's caregiver, PCP, CM, case coordinator, medical director, utilization management resource nurses, behavioral health expert and pharmacist. Ad hoc members who can be consulted as required and participate in the ICT include: community services representatives, nutritional support, rehabilitation specialists (occupational, physical or speech therapists), pastoral specialists and end of life specialists.

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: https://www.humana.com/