Amerigroup of Maryland Inc., H5896
Dual Eligible Medicare Zero Cost Sharing Special Needs Plan

Model of Care Score: 93.75%

Three Year Approval **January 1, 2012 – December 31, 2014**

Target Population

Amerigroup of Maryland's Dual Eligible SNP target population includes members who frequently report hypertension, diabetes and chest pain. About .3 percent of members are enrolled in hospice and 1.1 percent have a diagnosis of end stage renal disease (ESRD). More than half, 61 percent, of members are female and 47 percent of members are younger than 65 years, indicating a number of members are eligible for Medicare based on a disability.

Provider Network

Amerigroup maintains a network of contracted providers to meet the needs of our population. Every member selects a primary care physician (PCP). The networks include providers that have an expertise in managing the health care needs of dual-eligible and special needs members. Providers include, geriatricians, physical medicine and physiatrists, behavioral health providers, skilled nursing facilities (SNF), ancillary providers and facilities, cardiologists, endocrinologists, diabetes educators, dialysis centers, mental health providers and facilities and social workers and nursing professionals.

Care Management and Coordination

Case managers (CM) are responsible for completing the health risk assessment (HRA) within 30 days of enrollment and stratifying the results. The HRA assesses the member in multiple domains including physical health, mental health, functional, cognitive and psychosocial. The CM is responsible for documenting the HRA results in the case management system. At a minimum, re-assessments are performed annually unless there is a change in condition or health status.

The CM analyzes the risks identified during an analysis of the HRA in order to review them with the member or caregiver and includes them in the members individual care plan (ICP). Amerigroup also analyzes membership and provides risk stratification to identify members needing medical case management. Each member's ICP is based on the results of the initial HRA and a review of medical conditions, continuous case finding information, cultural preferences and other clinical documentation. The ICP is reviewed by the interdisciplinary care team (ICT) and updated as necessary. In addition to the ICP, each member receives a document to use as

their personal health record. It has sections for the member to maintain an accurate medication list, list of conditions, contact information to their family, caregiver, and physician, list of providers caring for the member, condition red flags and how to manage them, general office visit transition information, inpatient admission and discharge transition information and a place to document questions to ask the physician. The complexity of the member's condition, needs identified and the level of case management being performed are included in the ICP. The member is included as in the planning process so their preferences are considered when a care plan is being developed.

The ICT is a multi-member team that may consist of a medical expert, mental health/behavioral health expert, social services expert and other practitioners as determined by the member's needs. This team is responsible for analyzing and incorporating results of the initial and annual HRA, developing and annually updating members' ICPs, managing the physical, functional, cognitive and psychosocial needs of the members and communicating and coordinating the ICP. The ICT is based on the complexity of the member's condition, for example, low risk members may only have a nurse and a medical expert. Members who high risk or who have more complex care coordination needs, will have an ICT that follows "Intensive Case Management" procedures. These ICTs teams meet at least weekly and members include case managers, management personnel, medical directors, pharmacy, behavioral health providers, the member and social workers. Regardless of the composition of the ICT, the PCP is always included and responsible for coordinating the member's care. At a minimum, ICPs are reviewed and updated annually. When the CM determines there is a significant change in the member's condition, additional reviews will be scheduled.

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://www.amerigroup.com/