Amida Care, H6745
Chronic or Disabling Condition (HIV/AIDS) Special Needs Plan

Model of Care Score: 80%
3-Year Approval **January 1, 2014 – December 31, 2015**

Target Population

The target population for Amida Care is specifically designed for people living with HIV/AIDS (PLWHA). There are 1098 potentially eligible SNP members identified within the Medicaid SNP population. These 1098 members are aged 55-65 and are the group closest to the age of eligibility for the HIV/AIDS C-SNP plan. Approximately 10% of Amida Care's current members are high need, with complex co-morbid conditions including substance abuse (40%), hypertension (39%), infectious hepatitis (31%), chronic obstructive pulmonary disease including asthma (22%) and diabetes (20%). Over 40% are active drug users, an additional 40% have a history of drug abuse and 60% have a major mental illness diagnosis.

Provider Network

Amida Care's network is comprised of over 5,700 providers including 31 inpatient facilities. Other contracted providers include: 6 certified and 34 licensed home health agencies, 23 personal care agencies, 39 skilled nursing facilities, 20 audiology providers, 16 adult day care centers and 6 social daycare centers.

Amida Care maintains contracts with credentialed providers to ensure that members in the target population have access to care. Providers assess, diagnose and treat members in collaboration with integrated care teams (ICT) and provide 24-hour access to a clinical consultant. At the member level, providers assist with the development and updating of the individualized care plan (ICP) and participate in conference calls for interdisciplinary case reviews as needed.

Members have access to participating provider information through multiple sources, including an online provider directory (available on Amida Care's website). Member service representatives are available by phone or in the Amida Care borough offices to support members.

Care Management and Coordination

Care management is an individualized process and every member has their own individual care plan (ICP). Amida Care identifies patients based on their risk upon enrollment, intake into case management and then on an ongoing basis. Since the population is not in a static state, Amida Care has invested in systems and reports to identify patients who have a need for assistance.

Amida Cares' staff of nurse care coordinators, member service representatives and health navigators is available to assist members in maintaining a regimen of medically necessary care.

Amida Care analyzes its population using an electronic health record system. This is not only a source of patient identification but also provides data on disease and service use. The plan uses a prospective health risk assessment (HRA) for every member using clinical and utilization events that impact an individual's health risk. The HRA identifies higher risk individuals for complex case management as well as individuals who are at risk for catastrophic medical and financial outcomes, including one or more hospitalizations. The HRA software enables the plan to stratify members clinically and produce patient profiles for effective disease management interventions where intervention will have the greatest impact and immediate intervention opportunities for individual outreach. It is from this system that care coordination, individual care plans, and the ICT are built.

Amida Care's ICT supports care planning and management of care. The core of the ICT consists of: the member, team lead (a qualified clinical professional such as a nurse), care coordinator, health navigator, community outreach worker and case manager. Members are assigned to an ICT upon enrollment in the plan. The member's primary care provider (PCP) receives a letter from the Amida Care medical director explaining the care planning process for the ICT. The PCP and the member are invited to participate in care team discussions. If this is not possible then the individual member's care plan is sent to the PCP and the member. For complex cases, the ICT lead person may place a telephone call to the PCP to ensure engagement.

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://livelifeadvantage.amidacareny.org.