COMMUNITY HEALTH GROUP, H7086
Dual-Eligible (Medicaid Subset $0 Cost Share) Special Needs Plan

Model of Care Score: 85.00%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

Community Health Group's (CHG) primary targets are current Medicaid members who are also eligible for Medicare. Members are low-income individuals who are elderly or disabled and have extensive health care needs. CHG's membership is representative of the proximity to the Mexican border with 50% of the Medicaid membership Hispanic, 11% Caucasian, 9% Black, and 7% Asian. Ethnicity is unreported in 22% of membership. Fifty-six percent of the dual eligible population is female. Sixty-three percent of the Medicare population speak English, 25% speak Spanish, and 10% speak Vietnamese. Seventy percent of the current dual eligible population is 70 or older, 15% aged 50 or above. Diabetes is the most prevalent chronic disease among the plan's dual eligible members. Cardiovascular diseases (coronary artery disease, hypertension, congestive heart failure, and dyslipidemia), asthma and chronic obstructive pulmonary disease (COPD), and affective/schizo-affective disorders are also prevalent.

Provider Network

CHG contracts with primary care physicians, specialists, licensed nurses and ancillary providers such as social workers, pharmacists and facilities. The plan assess and augments its physician network, where necessary, to include specialists that may be treating new members. CHG has also established processes to provide care by non-contracted providers when care cannot be safely and appropriately rendered within the network. Contracted providers include clinicians to treat mental illness, including licensed mental health professionals to provide care in the members' home, if necessary.

Care Management and Coordination

CHG's health risk assessment (HRA) tool is used to conduct both the initial assessment and annual reassessment. The initial health assessment (IHA) is conducted within 90 days of enrollment. After 45 days of active enrollment, the personal care coordinator contacts the member to schedule the IHA. CHG's IHA is conducted by a contracted, credentialed, bilingual (English/Spanish) physician who performs an interview, brief physical exam and reviews the member's home environment to identify any safety issues and the need for home adaptive equipment. When necessary, a translator accompanies the physician.

CHG's interdisciplinary care team (ICT) includes key stakeholders such as the chief medical officer, director of utilization management, high risk case manager and behavioral health services. Additionally, the team may include the manager of member services, trainer/auditor, community and preventive services specialist, an applications coordinator and the primary care

physician (PCP). Team members are selected based on the extent to which they can contribute to the development, implementation, and assessment of a realistic and actionable individualized care plan (ICP). The ICT meets weekly at a regularly scheduled date and time to review new and existing cases, stratify the level of acuity, develop, assess and modify care plans. New cases are scheduled for review after the completion of the IHA.

The individualized care plan (ICP) is solidified during the discussion between the high risk case manager and the member and the member's care representatives. A copy of the ICP is subsequently faxed to the PCP who has the opportunity to modify based on their clinical judgment. The ICP addresses the member's current needs and potential needs over time based on the risk assessment. The ICP sets goals and objectives, lists specific services and benefits that are planned to meet the specific needs of the member, incorporates preferences and addresses barriers to care, sets schedules for follow-up and communication with the member, and incorporates outcome measures. Appropriate resources and tools are identified to address various aspects of the member's care, such as maximizing benefits (e.g., transportation and the installation of home adaptive equipment), community-based resources (e.g., in-home supportive services), identifying appropriate network providers (e.g., home-based visits for members who are unable to leave their homes and hospice care for members near the end-of-life) and CHG's established programs (e.g., health education/wellness classes and disease management programs)

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.chgsd.com/