**H7086 Community Health Group**
**Dual Eligible (Subset - Medicare Zero Cost-sharing) Special Needs Plan**

**Model of Care Score: 98.33%**
**3-Year Approval** **January 1, 2015 to December 31, 2017**

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## Target Population

Community Health Group's (CHG) Dual Eligible SNP members reside in San Diego County and are eligible for Medicare Parts A, B, and D as well as Medicaid (Medi-Cal). The majority of members receive these services from CHG. Seventy-four percent of CHG's members are 60 years or older and 53 percent are female. CHG's membership is 41 percent Hispanic, 25 percent Asian or Pacific Islander, 23 percent Caucasian and 10 percent Black. Spanish is the primary language of 28 percent of members and 11 percent members primarily speak Vietnamese. The majority of members have multiple chronic illnesses with varying levels of progression and acuity, an inability to care for themselves and also lack family and/or in-home support.

## Provider Network

CHG's primary care network consists of over 500 Medi-Cal primary care providers (PCPs), 15 Medi-Cal community clinic organizations, group practices and independent practice associations throughout San Diego County. Contracted community clinics include federally qualified health centers. CHG's Medi-Cal specialty network includes over 2,300 physicians representing all major specialties including but not limited to, internal medicine, endocrinologists, cardiologists, oncologists and mental health specialists.

CHG's contracted behavioral health network includes more than 200 providers, such as psychiatrists, licensed clinical psychologists and social workers and drug counselors. Many of these providers are able to provide services in various languages. The behavioral health network contracts with three licensed mental health professionals to provide care in a member's home, if necessary. CHG contracts with a county-wide health education network to provide culturally-sensitive and linguistically appropriate health education services.

CHG's network includes sub-acute facilities that provide medical "step-down" and rehabilitative care, long term acute care facilities, skilled nursing facilities (SNF), dialysis centers, free-standing diagnostic/radiology centers, laboratory services, home health agencies (which include access to skilled nursing, physical, occupational and speech therapies, social workers, registered dieticians and certified diabetes educators), pharmacies and durable medical equipment (DME) providers. CHG contracts with a medication therapy management (MTM) vendor that contracts

with pharmacies within CHG's contracted pharmacy network to provide MTM services to members.

**Care Management and Coordination**

CHG's health risk assessment tool (HRA) assesses members' physical, psychosocial, cognitive, functional and long term support services (LTSS) needs. Upon completion of the initial HRA, each member's case is discussed by the interdisciplinary care team (ICT). Members' risk scores are based on the HRA results, and provide the most vulnerable and highest risk members timely care that is proportionate to their needs. Within 365 days of the member's previous or initial HRA, an outreach specialist will schedule the annual HRA.

The ICT oversees, coordinates and evaluates the care delivered to members and incorporates the initial and annual HRAs to develop and update members' individual care plans (ICP). ICT members include the chief medical officer (CMO), director of utilization management services, case manager (CM), behavioral health services manager, member services trainer/auditor, community and preventive services specialist, outreach specialist, corporate quality specialist, the director of health care operations and PCPs. Members and their caregivers are invited to participate in ICT case review meetings.

The initial ICP, as well as any updates, are communicated to the member and/or their caregivers, the member's PCP and the ICT by the CM. The ICP sets self-management goals and objectives, lists specific services and benefits that meet the specific needs of the member, incorporates preferences for care, addresses barriers to care, sets schedules for follow-up and communication with the member and incorporates outcome measures. The quantity and level of services depend on the member's risk stratification.

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/medicare2014.aspx.