Peach State Health Plan by Centene, H7173
Dual Eligible (Dual Subset –Medicare Zero Cost Sharing) Special Needs Plan

Model of Care Score: 95.63%
3-Year Approval **January 1, 2014 –December 31, 2016**

Target Population

This plan enrolls members that are full benefit dual eligible and Qualified Medicare Beneficiaries (QMB) in Georgia. This population tends to be frail, subject to poor care coordination, high cost and has poor outcomes and a lack of community resources. The plan's model of care includes the delivery of specialized services and benefits to special needs members who are medically complex or have multiple chronic conditions, frail and disabled or at end of life. Examples of such members are those who suffer from diabetes, COPD, cardiovascular conditions, end-stage renal disease, HIV, dementia, depression, substance abuse or are in active treatment for cancer. Frail and disabled members include those with limited physical and/or cognitive function and require more frequent assessment.

Provider Network

The provider network consists of a wide range of providers and facilities such as, physicians, nurse practitioners, physician assistants, dieticians, hospitals, urgent care centers, long-term care hospitals, skilled nursing facilities, federally qualified healthcare centers (FQHCs), pharmacies, rehabilitative facilities, dialysis centers, behavioral health practitioners, dental specialists, vision specialists as well as providers that offer disease management programs and specialists that focus on chronic conditions such as cardiology, neurology, podiatry, endocrinology, pulmonology and orthopedics. Primary care physicians (PCPs) have responsibility to supervise, coordinate and provide all primary care to members and to initiate and coordinate referrals to specialty care. PCPs are responsible for developing, maintaining and updating member's individualized care and treatment plans (ICP).

The plan employs social workers, care managers, behavioral health care managers, program coordinators, member connections representatives, pharmacists and medical directors. The contracted team consists of primary care physicians (PCP), specialty care physicians, behavioral health providers, ancillary services, faith-based representatives, various state agencies and other participants as appropriate to the member's needs.

Care Coordination and management

The plan conducts a health risk assessment (HRA) designed to identify the needs of the most vulnerable members by evaluating medical, psychological, functional status and cognitive needs. Case managers contact members to conduct the HRA within 90 days of enrollment. After

completion of the HRA, the case manager determines the severity of each member's health and risks for future health problems and places the member into one of three categories (low, medium, high). The case manager or program specialists follow up with a condition specific assessment to develop the individualized care plan (ICP). The case manager also consults the plan's medical director and additional personnel involved with the member's care to help inform the ICP. To increase member participation in self-management and to improve health literacy, the plan offers member incentives. Plan pharmacists work with the medical director and member's PCP to reach out to members at risk for drug interactions or adverse drug events. They also outreach to members who are noncompliant with their medications.

The essential elements of the ICP include, but are not limited to: assessment, identifying problems, establishing goals (short and long-term), interventions, care coordination, monitoring and evaluation. The ICP and its interventions are intended to increase member self-management, improve mobility and functional status, reduce pain and create improved satisfaction with health status and healthcare services.

The plan has an interdisciplinary integrated care team (ICT) model. ICTs are generally comprised of clinical and non-clinical staff, led by medical directors. Non-clinical staff focus on care coordination and the clinical staff focus on the more complex, clinically-based service coordination needs. Case managers lead the ICTs and are responsible for facilitating communication among ICT members. Case managers and social workers are available onsite at plan-owned facilities. The goals of the ICTs and care management are: early identification of members that could benefit from case management services, increased awareness of plan benefits, and ongoing partnerships with area providers.

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://advantage.pshpgeorgia.com/