H7173 Peach State Health Plan, Inc.
Dual Eligible (All Dual) Special Needs Plan

Model of Care Score: 81.67%
2-Year Approval **January 1, 2015 – December 31, 2016**

Target Population

Peach State Health Plan, Inc. (Advantage by Peach State) Dual Eligible Special Needs Plan (D-SNP) is a state licensed care management organization with the Georgia Department of Community Health that provides services to Medicaid recipients. The target population includes dually eligible individuals who live in one of its 13 service areas in Georgia.

Male members slightly outnumber female members and most fall between 34-44 years old. The six most predominant disease states within the population consist of: cardiology (30 percent), orthopedic/rheumatology (20 percent), endocrinology including diabetes and cystic fibrosis (20 percent), nephrology (10 percent), behavioral/mental health and substance abuse (10 percent) and neurology including multiple sclerosis, chronic inflammatory demyelinating polyneuropathy, brain and sickle cell disease (10 percent).

Provider Network

Members have access to a wide range of credentialed and contracted providers that include physicians with specialties in: cardiac care, orthopedics, rheumatology, allergy, urology, dermatology, pathology, pulmonology, optometry, endocrinology, podiatry, neurology, hematology, nephrology, cardiology, obstetrics, gynecology, pediatrics, rehabilitative therapy and oncology. The network also consists of: nursing specialists that include nurse practitioners and physician assistants; dieticians and rehabilitative/restorative therapy specialists that include physical, speech and occupational therapy; oral health specialists that include dentists and oral surgeons; mental health specialists; pharmacists and medical equipment suppliers. In rare instances where in-network services are not available, the interdisciplinary care team (ICT) coordinates members' access to out-of-network providers.

The types of facilities in the network encompass: hospitals and emergency departments, urgent care centers, outpatient care centers, long-term care hospitals, laboratories, skilled nursing facilities, federally qualified healthcare centers, rural healthcare centers, pharmacies, radiography facilities, rehabilitative facilities, dialysis centers, outpatient surgery centers, hospice, home health agencies and infusion centers.

Care Management and Coordination

Within 90 days of enrollment and annually thereafter, a case manager (CM) conducts an initial health assessment/risk stratification (HRA) with each member by telephone. The HRA identifies the member's medical, psychological, functional and cognitive needs. The assessment also gauges the member's medical and behavioral health history to coordinate his or her care. Based on the member's risk stratification score, he or she receives a referral to a RN case manager (high, moderate and low risk members with clinical needs) or a program specialist/social worker (low risk members who do not have clinical needs, but require care coordination).

The interdisciplinary care team (ICT) creates the individualized care plan (ICP) based on the HRA results and information obtained from the member, his or her caregiver and providers involved in the member's care. The essential elements of the ICP include: in-depth information about the member's health/functional status, prioritized goals with measurable outcomes, barriers to meeting the goals or complying with the ICP, case management activities and/or interventions to accomplish the goals and a self-management plan. The CM performs on-going assessments to evaluate the member's progress toward the goals and/or identify barriers impeding goal achievement. The CM completes a reassessment annually, at a minimum, and whenever the member experiences a significant change of condition.

A board certified medical director leads the ICT, which includes: the CM, social workers, behavioral health care managers, program coordinators, member representatives and pharmacists. Based on the member's needs, the following providers may also participate in the ICT: a primary care physician, specialty care physicians, a nurse practitioner, a mid-level practitioner, a registered nurse, therapists, a dietician, health educator, a disease manager, a behavioral/mental health specialist, a community resources specialist, a dentist and faith-based representatives. The ICT reviews members' progress during its twice-weekly case management reviews.

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/