H8170 America's 1st Choice of South Carolina Inc.
Chronic Conditions (Cardiovascular Disorders, Chronic Heart Failure and/or Diabetes)
Special Needs Plan

Model of Care Score: 100.00%
3-Year Approval **January 1, 2015 to December 31, 2017**

Target Population

America 1st Choice's Chronic Combined SNP (Combined C-SNP) targets Medicare members with congestive heart failure (CHF), cardiovascular disorders (CVD; limited to cardiac arrhythmias, peripheral vascular disease, or chronic venous thromboembolic disorder) or diabetes mellitus (DM). The Combined C-SNP is offered in three metro counties in South Carolina. Most members speak English as their primary language.

As of January 2014, 57 percent of C-SNP members were male and most members were 75 years and older. There is a disproportionate share of low income members, and members frequently require social services, including assistance with activities of daily living (ADLs), assistance within their homes and with transportation. C-SNP members tend to have a lower health literacy level compared to other Medicare members. Members exhibit forgetfulness or attitudes or preferences not conducive to change. While diabetes, CVD and CHF diagnoses are often correlated, members with these conditions also tend to have comorbidities including neurological disorders, musculoskeletal disease, pulmonary disease, kidney disease and psychiatric disorders.

Provider Network

The network includes contracted providers with specialized clinical expertise pertinent to the target C-SNP membership. This includes: internists/primary care physicians (PCP), cardiologists, cardiovascular surgeons, neurologists, endocrinologists, optometrists, ophthalmologists, podiatrists, nephrologists and orthopedic surgeons, providers specializing in geriatric medicine and family practice. The network also includes acute care hospitals and tertiary medical centers, acute care rehabilitation facilities, laboratory providers, skilled nursing facilities (SNF), pharmacies, radiology facilities, outpatient diabetes management and cardiac rehabilitation centers and wound care centers.

Care Management and Coordination

All members receive an initial comprehensive health risk assessment (HRA) within 90 days of enrollment and an annual HRA thereafter. A disease specific health assessment (DSHAT), is also administered within 90 days of enrollment, and again annually, and is based on the member's

specific disease. The assessments are used to stratify members into one of three tiers and also help develop members' individualized care plans (ICP). The ICP includes three components: problems, goals and interventions. Community services and resources as well as caregiver resources are integral parts of the ICP, personal preferences including religious or cultural and ethnic needs are also taken into account.

Members stratified into tier 1 receive a disease-specific ICP that is appropriate for all individuals with the same or similar diagnosis. Members without a known disease are also stratified into tier 1, and they receive and ICP that addresses common barriers and challenges experienced by members sharing similar socio-economic backgrounds (i.e., unmet transportation needs, difficulty with copays, etc.). Members stratified into tier 2, receive ICPs that are generated by the member's disease specific HRA responses and pharmacy data and claims experience. Tier 3 ICPs are the highest level of care and are for the most vulnerable beneficiaries.

The C-SNP subscribes to the "medical home" model in which the member's PCP is responsible for all medical decision making and the member's well-being. The case manager (CM) supplements the process by serving as a member advocate and navigator across the care continuum. The CM's role in is to ensure members get needed services as prescribed by the PCP when and where they need them. Each member receives coordination of services and benefits through the activities performed by the "member" and "plan" interdisciplinary care teams (ICT). The PCP is the member's primary contact, directs the ICP and engages the member's ICT. The following providers make up the member ICT: PCP, specialist, plan medical director, utilization management (UM) personnel, CM or social worker and the caregiver or support network. As needed, additional expertise is added to create a more personalized, focused team unique to the member's health condition. The plan ICT meets quarterly and is composed of health plan administrative and clinical personnel and consulting physicians. The plan ICT membership is reviewed at least annually for appropriate clinical and administrative expertise.

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: https://sc.americas1stchoice.com/