Amerihealth District of Columbia Inc., H8491
Dual Eligible Subset Medicare Zero Cost Sharing Special Needs Plan

Model of Care Score: 87.50%
3-Year Approval **January 1, 2012 to December 31, 2014**

Target Population

The target population for AmeriHealth is members who qualify for Medicare Part A and B and Medical Assistance. This includes members who are eligible for QMB only, QMB+ and SLMB+. The dual-eligible population has significantly higher rates of serious health conditions, physical impairments and cognitive limitations than others in Medicare and the common conditions of this population are coronary heart disease, colorectal cancer, breast cancer, stroke and diabetes.

Provider Network

AmeriHealth makes its best efforts to contract with a sufficient number of providers to serve its members and maintain appropriate access to primary care services, specialty services, behavioral health care services and facility providers. Its provider network includes primary care practitioners and specialists with expertise in geriatrics, orthopedics, cardiac care, diabetes and endocrinology, cancer and behavior health, which are in parallel with the top conditions found in the target population.

The ancillary provider network includes established free standing surgery centers, dialysis centers, home care agencies, skilled nursing facilities and home equipment providers.

Care Management and Coordination

AmeriHealth uses a health risk assessment (HRA) tool to collect information on a member's general health, level of activity, behavioral health, physical health, medication usage, medical and health history and preventive health history. The HRA completed within the first 90 days of enrollment and outreach is prioritized by identifying members who have high needs. As needed, the plan will conduct a home visit or meet with the members at the physician's office to complete the HRA. The members update their HRA annually, unless their condition changes or planned or unplanned transitions occur.

Case managers (CM) uses data from the HRA combined with other available information on the members, such as age, sex and utilization history from claims, to develop the individual plan of care. CMs are registered nurses or licensed social workers with a wide variety of clinical

experience. Each plan of care includes problem statements, short and long-term goals, planned interventions and resources, timeframe for reevaluation, planning for continuity of care (including transitions of care) and collaborative approaches (including member and family participation). The plan of care is reviewed by the care coordination team and the member/designated caregiver at the time when it is created and then a copy is sent to the member, primary care physician (PCP)/medical home and other key interdisciplinary care team (ICT) members. The care coordination team consists of registered nurses, pharmacists, medical directors, licensed social workers and non-clinical care connectors. The plan of care is updated annually and as needed as changes in the member's health status are identified.

The composition of the ICT varies according to the member's individual care needs. In addition to the member and/or caregiver, ICT members may include health plan physicians, nurses, social workers and pharmacists, PCP, specialists and ancillary providers involved in the member's treatment and community resource staff, such as the local Area Agency on Aging. ICT meetings are held as frequently as needed based on the member's clinical situation and care needs. Meetings are usually held by phone.

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://www.amerihealth.com/