Metroplus Health Plan, H0423
Chronic or Disabling Condition (HIV/AIDS)
Special Needs Plan

Model of Care Score: 88.75%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

MetroPlus Health Plan offers a Chronic Disease SNP. The MetroPlus Advantage Partnership in Care Plan (HMO) is open to individuals living with the chronic condition of HIV/AIDS, including both dual-eligible and non-dual eligible beneficiaries. The overall goal of the MetroPlus Chronic Conditions SNPs is to coordinate care and access to services and benefits. MetroPlus Partnership in Care has 130 members of which 34% are female and the average age is 57. The majority of members live in Brooklyn, 38.6%, followed by 25.7% in the Bronx, 20% live in Manhattan and 16% reside in Queens. MetroPlus Partnership in Care Plan supports the HIV Care Continuum Initiative, established by Presidential Executive Order in July 2013, and is focused on engaging and maintaining beneficiaries in care with the ultimate goal of HIV viral load suppression. Enhanced case management services are focused on co-management of HIV and other chronic conditions, including mental health and substance use, hepatitis C, diabetes, asthma/COPD, heart disease and members with frequent admissions.

Provider Network

The MetroPlus network includes over 12,000 primary care physicians (PCPs), specialists and other provider offices. In addition to hospital-based providers, MetroPlus members can also obtain primary and specialty care services at community-based doctor's offices and neighborhood family care sites. Medicaid, Child Health Plus, Family Health Plus and MetroPlus Gold members can receive primary care and specialty services at HHC's 11 hospitals and six Diagnostic & Treatment Centers. Specialized expertise in diabetes/endocrinology, neurology, gastroenterology, cardiology, behavioral health and joint disease are required in order to meet the identified specialized needs of MetroPlus's members.

Care Management and Coordination

Each new MetroPlus SNP member is contacted by letter and telephone to complete a health risk assessment (HRA) within 90 days of enrollment and annually thereafter. The assessment includes such items as health status, hospitalization/emergent care, clinical history, care utilization, functional status, including pain assessment, mental health status, caregiver resources and health promotion and screening. A score is automatically calculated based on the results of the HRA and is used to automatically stratify members for case management intervention as high, moderate or low risk.

Individualized care plans (ICPs) are developed from the analysis of the HRA, available claims, utilization and pharmacy data if available. Member's health needs are stratified by clinically knowledgeable personnel who review the assignment of members to a high, moderate or low

case management category in relation to their risk scores. In conjunction with the member and/or the member's caregiver, the MetroPlus case managers develop a care plan individualized to that member's specific needs. The individualized care plan (ICP) may include, but is not limited to the following: short and long-term goals, self-management goals, resources and specific services and benefits to be utilized, including the appropriate level of care, any required coordination of the member's Medicaid and Medicare benefits, planning for continuity of care, including transition of care and transfers, potential barriers to achieving the identified goals, collaborative approaches to be used, including family participation, providing educational materials and one-on-one education, and identification of measurable outcomes.

MetroPlus assigns each SNP member to an interdisciplinary care team (ICT). At a minimum, the ICT includes the following: MetroPlus's medical director, associate director of medical management- Medicare, mental health and/or behavioral health expert, health educator, utilization care managers, social worker, case manager, Medicare SNP member/ caregiver and member's PCP. Depending on the need, the ICT may also include other health care professionals, including but not limited to: nursing professional, pharmacist, nutritionist, pastoral specialist, disease management specialist, home care provider and physical and/or occupational therapist. The purpose of the ICT is to assist the member with coordination of care and assist the member with managing transitions of care. A draft of each member's initial care plan is shared by the case manager with the ICT for review and any additional recommendations. Once the care plan has been approved by the ICT, a copy is sent to the member and the member's PCP.

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 member needs.

For more information about this health plan refer to the Special Needs Plan's website at: www.metroplusmedicare.org