H0423 MetroPlus Health Plan
Dual-Eligible (Dual-Eligible Subset – Medicare Zero Cost-Sharing) Special Needs Plan

Model of Care Score: 90.00%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

MetroPlus Health Plan provides care to residents of Brooklyn, Bronx, Manhattan and Queens New York. This plan targets members that are dually eligible for Medicare and Medicaid and qualify for Medicare zero cost sharing benefits based on Medicaid income status and eligibility.

MetroPlus Advantage/Select has 6,236 members, of which 57.8 percent are female and 42.2 percent male. Over 68 percent of the members are over the age of 65. The percentage of members under age 65 years (32 percent) is slightly lower than the national dual eligible SNP enrollment. The majority of members live in Brooklyn (38.6 percent), followed by the Bronx (25.7 percent), Manhattan (20 percent) and Queens (16 percent). Based on zip code, members live predominantly in lower socioeconomic neighborhoods of the five boroughs, concentrated in 15 of the 42 neighborhoods that comprise the City of New York. These neighborhoods are characterized by high poverty rates, lower educational levels and predominantly minority populations.

The rate of poverty in the neighborhoods of dual-eligible members averages 29 percent in comparison to New York City's (NYC) average of 21 percent. The number of seniors (10 percent) living in these neighborhoods is lower than the average in NYC (12 percent). The poor health status reflects in the higher incidence of deaths in the dual member's neighborhoods (847 per 100,000) compared to NYC (718 per 100,000).

Provider Network

MetroPlus maintains a network of facilities and providers throughout New York. The network includes over 16,000 primary care providers, specialists and other provider offices. In addition to hospital-based providers, MetroPlus members obtain primary and specialty care services at community-based doctor's offices and neighborhood family care sites. Members also access primary care and specialty services at 11 different hospitals.

MetroPlus contracts with a practice for house calls, which consists of licensed physicians and nurse practitioners. This practice includes a network of specialty care resources including podiatry, optometry, nutrition, pain management and dermatology. Services provided include, in-home diagnosis, treatment of acute/chronic conditions, medication reconciliation, blood tests, X-rays, EKG's, sonograms, telemetry and physical exams. In addition to a contracted house calls practice, MetroPlus employs a nurse group which makes home visits to members.

Care Management and Coordination

MetroPlus uses a care coordination process which begins with a health risk assessment (HRA). The plan contacts each member by letter and telephone to complete an HRA and complex needs assessment within 90 days of enrollment, and annually thereafter. The assessments include an evaluation on member's physical, behavioral and social health status. After completion of the HRA, MetroPlus uses a tool to stratify SNP members by health and risk status. The tool accurately predicts the risk of inpatient utilization based on information provided to the questionnaires. Members are stratified into three risks for hospitalization: high risk, moderate risk and low risk based on a risk prediction model.

Following completion of the HRA, the plan develops individual care plans (ICP) based on the results. The ICP uses claims, utilization and pharmacy data if available. In conjunction with the member and/or the member's caregiver, a case manager develops the ICP to meet prioritized goals. In addition to prioritized goals, the care plan also includes barriers to achieving goals such as financial concerns, cultural constraints and lack of family support. The case manager works with the member to develop strategies for overcoming these barriers.

Once MetroPlus develops the ICP, the plan draws on different specialties to assemble an interdisciplinary care team (ICT). The composition of the ICT reflects the medical needs of each member. Plan staff are responsible for assuring clear and timely communications amongst the ICT, providers of care and community based programs. Core ICT members include, a team leader, case manager, utilization manager, health educator, case manager associate, Medicare member advocate, social worker, behavioral health case manager and the members' primary care provider. MetroPlus considers the member a part of the ICT and solicits their input regarding care plan goals.

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: www.metroplusmedicare.org.