HealthPlus of Michigan H2354

Dual Eligible (Medicare Zero-Cost-Sharing) Special Needs Plan

Model of Care Score: 87.50%

3-Year Approval **January 1, 2013 – December 31, 2015**

Target Population

HealthPlus offers a dual-eligible Special Needs Plan (D-SNP) to members who are eligible for Medicare and entitled to receive additional medical assistance in Michigan--otherwise known as Medicaid benefits. The plan serves members in Arenac, Bay, Clare, Genesee, Gladwin, Gratiot, Huron, Ingham, Iosco, Isabella, Lapeer, Macomb, Midland, Oakland, Saginaw, Sanilac, Shiawassee, St. Clair, Tuscola, Washtenaw and Wayne counties. Currently 79% of the population has one or more chronic condition and 15% have one or more hospital dominant condition or greater than 50% chance of an admission or readmission in the next 12 months.

Provider Network

HealthPlus partners with a primary care workforce for its managed care programs. These physicians have experience providing care for aged, blind and disabled Medicaid members and frail elderly Medicare Advantage members. The service area covers 21 counties in lower and central Michigan with a network consisting of: primary care, specialty care, acute care, behavioral health, pharmacies (including specialty pharmacy), laboratory, long term care, diagnostic and rehabilitation care, ambulatory care, home health, ancillary, durable medical equipment and end of life care.

HealthPlus has established standards for access and availability for providers and network adequacy is based on geographic distribution and number and type of providers relative to the membership base. HealthPlus conducts an annual review of these standards to ensure that the network is sufficient and subsequently develops and implements corrective action plans to address gaps in the network composition or distribution.

Care Management and Coordination

Every member has an initial individualized care plan (ICP) developed by the HealthPlus care navigator based upon identified needs from the member's responses to a health risk assessment (HRA). If a member requires case management, a case manager contacts the member to collaboratively develop a comprehensive case management plan face-to-face with the member or by phone. As part of this process, the case manager makes up a schedule of follow-up calls or appointments with the member. Finalized care plans are documented electronically in the case management system and copies are either printed and mailed or sent electronically to the member each time the SNP updates the care plan.

HealthPlus encourages members to review the care plan with their physician. The member, family, caregiver, case manager, primary care physician and practitioners actively participate in the development of the case management plan and any revisions, with the interdisciplinary care team (ICT). Prioritizing needs, problems, goals and interventions with the member's or caregiver's input and agreement helps to address clinical outcomes.

The ICT is composed of a diverse group of clinical staff. At a minimum, the team includes: the member or caregiver, medical case managers, nurses, care navigators -- social workers (LMSW/LBSW), a psychiatrist, pharmacists, behavioral health case managers, primary care physicians (PCP) and the medical director. The unique medical needs of the member are considered in composing the ICT. HealthPlus encourages members and their caregivers to participate in their own healthcare by actively collaborating with their case managers and 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.healthplus.org/medicare.aspx