H2422 Health Partners, Inc.,
Dual Subset Medicare - Zero Cost Sharing Special Needs Plan

Model of Care Score: 98.33%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

HealthPartners (HP) serves individuals who: 1) are age 65 and older, 2) eligible for Medicaid and enrolled in Medicare Parts A and B, 3) live in the community (in a private home or in an assisted living facility) or a nursing home and 4) are located in one of the following 12 contiguous Minnesota counties: Anoka, Benton, Carver, Chisago, Dakota, Hennepin, Ramsey, Scott, Sherburne, Stearns, Washington and Wright.

HP members are categorized into three nursing home eligibility categories: community nursing home certifiable, community non-nursing home certifiable and nursing home certifiable in a long-term care facility with the percentage of the total member population representing 42 percent, 39.8 percent and 18.2 percent of these categories respectively. Females dominate membership at 69.3 percent and the two predominant cultures represented among the population are White (51.8 percent) and Asian or Pacific Islander (28.7 percent). Consequentially, the dominant languages are English (74.3 percent) and Vietnamese, Hmong, or Cambodian (22.7 percent). The top four chronic care conditions in this population are: diabetes (77.2 percent), coronary artery disease (93.3 percent), heart failure (96.5 percent) and chronic obstructive pulmonary disease (96.2 percent).

Members face barriers to care including poor health literacy and an inability to speak and/or read English which impacts their capacity to obtain, process and understand basic health information and services needed to make health decisions. Additionally, the high prevalence of mental health conditions for members with multiple comorbidities causes additional complexities in managing their health care.

Provider Network

The provider network is composed of primary, specialty, geriatric and dental care providers as well as transportation providers and interpreters. These providers have training and experience in managing medically complex and/or chronic conditions and provide diagnostic and treatment services to meet the specialized needs of HP's member population. HP members have access to a full range of hospitals, acute and post-acute facilities, rehabilitation centers, long-term care services, home and community-based services. Additionally, the plan has developed relationships with community partners such as county partners, senior centers and health and

wellness programs in order to enhance their ability to provide coordinated care and continuity of services.

Care Management and Coordination

Upon enrollment, the care coordinator (CC) administers the health risk assessment tool (HRAT) to the member face-to-face. The HRAT includes an assessment of the member's medical, functional, psychosocial, cognitive and mental health needs as well as their needs for primary, acute and long-term care. In addition to HRAT completion, the health risk assessment process includes a review of medical records, service claims and utilization records.

The individualized care plan (ICP) is developed to address member needs identified by the HRAT. The essential components of the ICP include the member's self-management goals and objectives, personal healthcare preferences, a description of services specifically tailored to the member's needs and identification of goals.

Both the HRAT and the ICP are documented in an electronic documentation system. Updates and modifications of these documents are proactively communicated to the member, the member's caregiver, the interdisciplinary care team (ICT) and other associated personnel verbally by telephone, in person, fax, electronic medical record, email or mail.

The core members of the ICT are the member, caregiver, CC and primary care provider. Specialists such as clinical care managers, inpatient case managers and behavioral health case managers may be added to the ICT as appropriate for the specific member's health care. The CC monitors progress toward goals identified in the member's ICP, facilitates communication among ICT and disseminates pertinent information to the ICT as member needs and ICP elements change.

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.healthpartners.com\msho