H2470 Total Aging in Place Program, Inc.
Dual Eligible (Dual Eligible Subset) Special Needs Plan

Model of Care Score: 100.00%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Total Aging in Place Program, Inc. (TAIP) serves full dual adults (age 21 and over) with Medicare Parts A and B, residing in the New York State counties of Erie and Niagara. TAIP expects to serve approximately 560 dual eligibles across both counties in 2015, reaching an expected total of 870 in 2017. Given that 68 percent of the dual eligible population is over the age of 65, 62 percent are female and 20 percent have five or more chronic conditions, the profile of a "typical" dual eligible member is a white female over age 55 with one or more chronic conditions.

Among the dual eligible population the leading five chronic conditions are: heart disease (41 percent), diabetes (35 percent), depression (28 percent), congestive heart failure (26 percent) and arthritis (25 percent). In Erie County and Niagara County, 34 percent of those age 65 and older experience some type of disability, compared to 13 percent for the total population. The leading five causes of morbidity are overweight or obesity, hypertension, active smoking, diabetes and cardiovascular disease; their rates are still higher than state-wide averages. Both counties experience hospitalization rates above the state average.

Provider Network

Members of the TAIP network have access to hospitals, home health agencies, skilled nursing facilities, surgical centers, laboratory services, behavioral health facilities (ambulatory, inpatient, residential), transplant centers, pharmacies, and mental health and substance abuse services. In an effort to improve access to care and quality of life for its members and decrease costs, TAIP is exploring telemedicine and telemonitoring technologies. TAIP posts its up-to-date *Provider Directory* online and mails hard copies to prospective members, members and their family/caregiver, as well as providers and staff upon request.

Care Management and Coordination

Within 90 days of enrollment, all members complete a health risk assessment tool (HRAT) designed to assess their medical, functional, cognitive, psychosocial and mental health needs. The member's care manager (CM) administers the HRAT to the member telephonically or in person, either during a home or primary care physician (PCP) visit. The PCP is responsible for performing a comprehensive evaluation of new members within 60 days of their effective enrollment and an annual evaluation in support of providing direction for the overall care plan. HRAT reassessments are scheduled based upon

the member's risk-stratification level (annually for low and medium-risk and semi-annually for high-risk). If there is a change in the member's health status, a request for a reassessment by the member or a trigger event, a reassessment prior to the next scheduled one might be warranted.

The interdisciplinary care team (ICT) utilizes the findings from the HRAT, supplemental health assessments, and additional input from the member and/or caregiver to develop an individualized care plan (ICP) and determine what specific services and benefits are needed by the member in order to accommodate their preferences, overcome barriers to goal attainment and meet the identified treatment goals. The frequency of subsequent reassessments and ICT meetings, based on the member's risk level, is also discussed.

TAIP's ICT provides a strong foundation for timely and effective communication about members' care needs, progress and any gaps in care. All medical and behavioral health providers involved in the member's treatment are invited to participate in the ICT. Members and their families/caregivers or designated representatives are also encouraged to participate in the ICT. The ICTs have various ways to communicate, including: directly through ICT meetings, either in-person or via conference call; electronic communication among ICT members; or through the navigator, who provides ongoing monitoring and updates to the member's PCP and other ICT members, as needed, 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: http://www.fchp.org/