H2773 Quality Health Plans of New York, INC.
Chronic or Disabling Condition (Cardiovascular Disorders, Chronic Heart Failure, and/or Diabetes) Special Needs Plan

Model of Care Score: 71.67%
1-Year Approval[1] **January 1, 2015 – December 31, 2015**

Target Population

Quality Health Plans of New York (QHPNY) operates a Medicare Advantage plan in the State of New York. The plan caters to chronic condition special needs plan (C-SNP) members. In order for a member to qualify for enrollment they must have received a diagnosis of chronic heart failure, cardiovascular disorder and/or diabetes. QHPNY has 39 members in its Chronic SNP, of which 13 percent have a diagnosis of chronic heart failure, 41 percent have a cardiovascular disorder and 46 percent have diabetes.

Approximately 46 percent of the current chronic SNP population is female, and 54 percent of the population is male. QHPNY's analysis of age shows that 100 percent of male and female members are over the age of 65. Out of this elderly population, the majority (79 percent) identifies as Caucasian.

Provider Network

The QHPNY contracts with a provider network to meet the needs of the target population. The network consists of providers and facilities pertinent to the care of C-SNP members that have chronic heart failure, cardiovascular disorder and diabetes. This includes, but is not limited to, institutional facilities, primary care providers, behavioral and mental health, nursing, ancillary services and allied health professionals. These providers undergo a peer referral process and credentialing/privileging process.

Members have access to their primary care physician (PCP) and the New York Department of Health to receive community based care. Community services available to members are adjusted on a yearly basis to coincide with the plan benefit package. On a monthly basis, QHPNY receives a report identifying access and utilization rates of QHPNY members for each type of community service. QHPNY uses the report to evaluate the effectiveness of the model of care, as well as the availability of network resources for members

[1] Per CMS guidance, plans that use the cure process receive a one-year approval, regardless of their final score.

Care Coordination

Care Coordination commences at the time of enrollment. From the initial contact with a member, the marketing department and the customer service department educate the member about available benefits. Once enrolled, the plan calls each member through an outreach team. The team performs a health risk assessment (HRA), conducts disease management education, assists in transition of care needs, and acts as liaison between members and providers to coordinate care.

After performing the initial assessment, QHPNY analyzes and stratifies the results of the HRA. The stratification results in one of three categories: (1) high intensity, (2) moderate intensity and (3) low intensity. Based on the results of the outreach team assessment and the HRA, the plan creates an individual care plan (ICP) for each member.

QHPNY incorporates elements into the ICP which includes clinical history, social history, advance directives, power of attorney declarations, care giver information, HRA results and intensity level, disease management education, encouragement of responsibility for self-care and determination for additional services. Additionally, members and/or their caregivers participate in the individual care planning process by phone, in writing, through web-based electronic interfaces and virtual correspondence.

Once a member receives their ICP, the plan forms an interdisciplinary care team (ICT) based on the unique needs of each member. The core composition of a member's ICT includes a nurse coordinator, pharmacy director, medical director, PCP, mental health specialist and social services specialist. QHPNY invites additional participants on an as needed basis, or as the member's health status changes. The plan encourages the participation of the member in the ICT whenever possible.

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: qualityhealthplansny.com.