Touchstone Health, H3327
Dual Eligible (Medicare Zero Cost-Sharing) Special Needs Plan

Model of Care Score: 97.50%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

Touchstone serves dual-eligible members in Bronx, Kings (Brooklyn), Orange, Queens, Richmond (Staten Island) and Westchester Counties of New York State. Out of the 1,610 Touchstone Special Needs members, 902 of them are female and 708 of them are male. Eighty-six percent of the members are in the age range of 50 to 89.

Provider Network

Touchstone has a provider network equipped to meet and manage the needs of the target population, including sufficient primary physicians, specialists and a wide range of facilities. In addition, a wide range of participating clinicians and contracted facilities allows SNP members to receive easily accessible, affordable, medically necessary care and services in network. Seldom do SNP members require medically necessary care from non-participating clinicians or facilities; however, if the member must receive medically necessary services out-of-network, the contracting department negotiates a cost-effective rate.

Care Management and Coordination

Within 90 days of enrollment and annually, Touchstone personal care advocates make three attempts to contact the members to fill out the health risk assessment (HRA) and then send a paper HRA to the members if they are not reached within the first 30 days. Touchstone's HRA tool is a questionnaire that addresses the member's medical conditions, medical history, mental health history, psychosocial issues, functional status and cognitive needs. It serves as a clinical roadmap for assessing each SNP member.

After the completion of the HRA, the case manager reviews the HRA and groups the SNP members based on the complexity and severity of any existing disease process and their risk for hospitalization, especially if the member has any ambulatory care sensitive conditions. Stratification categories include preventive maintenance, disease management (CCIP) and complex case management. Additionally, the case manager assigned to the member reviews the member's HRA to identify the member's medical needs and their non-medical needs including but not limited to psychosocial issues, the level of caregiver support available, cognitive

challenges, physical functionality, cultural and linguistic preferences, knowledge gaps, the member's ability to self-manage and any other potential barriers to care.

The HRA and the additional data gathered from the member and/or caregiver are used to develop the care plan. The case manager also collaborates with the rest of the interdisciplinary care team (ICT), including ad hoc members as appropriate, to tailor a care plan that addresses the member's unique needs. The case manager updates a member's care plan annually or whenever the member, the caregiver or the PCP communicates a change in the member's health status.

The ICT coordinates care across disciplines and across care settings and contributes to the development and implementation of members' care plans. This includes reducing any barriers to medication adherence and attending physician appointments. The members of the ICT are chosen based on their expertise and ability to effectively address the clinical and psychosocial issues commonly encountered when comprehensively managing the care of SNP members. The ICT for each SNP member includes, at a minimum, a medical director, a case management program manager, a case manager, a social worker, a licensed clinical pharmacist and a personal care coordinator. Other ICT participants vary depending on the SNP member's needs and may include the member's PCP or specialist, a behavioral health vendor, ancillary health care providers, hospitalists and in-home care clinicians. The ICT has weekly face to face meetings to review care plans for SNP members.

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.touchstoneh.com/enroll/search/plans.aspx