**HIP Health Plan of NY (EmblemHealth), H3330**
**Dual Eligible (All Duals) Special Needs Plan**

**Model of Care Score: 96.88%**
**3-Year Approval** **January 1, 2012 – December 31, 2014**

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## Target Population

HIP Health Plan of New York (HIP) under EmblemHealth (parent organization) serves individuals that live within its service area, are eligible for Medicare Part A and B and also Medicaid through the state of New York. HIP's enrollment has a combined membership of 9,707 members with majority of the gender being females and ages 65 and older. Many members have some kind of disability. The EmblemHealth Dual Eligible (HMO SNP) service area is the five boroughs of New York City, Nassau, Suffolk and Westchester counties.

## Provider Network

The EmblemHealth provider network offers a comprehensive medical and ancillary delivery system throughout the Medicare service area with 106,000 physicians and other health care professionals at nearly 172,000 locations across the service area. Specifically, the HIP SNP provider network offers 153 unique languages spoken in provider offices. EmblemHealth contracts with individual providers in primary and specialty care services in all of the following areas: medical specialists (e.g., cardiology, nephrology, psychiatry, geriatric specialists, pulmonologists, immunologists); behavioral and mental health specialists (e.g., drug counselors, clinical psychologists, social workers); nursing professionals (e.g., nurse anesthetists, nurse practitioners,) and allied health professionals (e.g., physical therapists, occupational specialists, speech pathologists, radiology specialists).

## Care Management and Coordination

The health risk assessment (HRA), also called health risk survey, is sent to all members to be completed within 30 days of enrollment. If a member is able to perform the HRA via telephone, it is completed at that time. Re-assessments are performed annually from the date of completion of the initial HRA. The stratification assists in determining where the member can be referred to for further outreach and evaluation. Reporting is designed to identify members "at risk," members with selected conditions, diseases or services, and members needing or requesting condition specific services offered by EmblemHealth, which includes but is not limited to durable medical equipment, home care services and appointments with a primary care provider. All HRAs are uploaded electronically in the system to ensure access for all providers.

The plan of care (ICP) is developed by the RN case managers on the team. When a member is accepted into the case management program, an assessment is administered by one of the nurses on the clinical team to either the member or a person that they designate. The areas of focus include but are not limited to medical, behavioral health, psychosocial and pharmacologic needs. The survey is programmed to auto-generate a plan of care, with member centric problems, goals

and interventions based upon the survey responses. Upon completion of the survey, the case manager reviews the ICP and makes additional customizations as needed. Once completed, the ICP is mailed to the member's primary care provider to ensure the provider is aware that the member is in the EmblemHealth case management program.

The interdisciplinary care team (ICT) is comprised of a multidisciplinary team which includes but is not limited to, a medical director, the senior director of care and case management, the director of utilization management, and the manager of complex case management, as well as frontline staff within the respective departments. The frontline staff includes the following: licensed social workers, nurses, case managers, utilization management agents, mental health staff, registered dieticians and ancillary support staff. The team has a member-centric approach that manages the member's health care needs across the health care continuum. The participation of the member is facilitated whenever possible, by identifying which providers the member would prefer to see and to maximize involvement in decision-making regarding care and preferences, as much as possible. The team meets several times a week in person or 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 member needs.

For more information about this health plan refer to the Special Needs Plan's website at:
www.emblemhealth.com/our-plans/medicare