H3330 HIP Health Plan of New York
Dual Eligible (All Dual) Special Needs Plan

Model of Care Score: 90.00%
3-Year Approval **January 1, 2015 to December 31, 2017**

Target Population

The service area for the HIP Health Plan of New York (HIP) Medicare HMO Special Needs Plan (SNP), an EmblemHealth plan, is the five boroughs of New York City, Nassau, Suffolk and Westchester counties. The plan has 8,204 members, with highest enrollment in Queens, Kings, Bronx and Nassau. The plan is designed for members who enroll without a retiree group benefit, members in a Medicaid Advantage plan and members that are in a Managed Long Term Care (MLTC) plan, which provides care for a medically challenged fully Medicaid eligible population at home.

Based on claims data from December 2012-November 2013, the average age of all SNP members is 67.4 years old. About 24 percent of members are younger than 65, which indicates many members are eligible based on a disability. There are significantly more female than male members. The largest racial group is the Caucasian/White population (42.4 percent), followed by African Americans (37.2 percent), Hispanic (12.3 percent), Asian/Hawaiian/Pacific Islanders (6.8 percent) and other/American Indian/Alaska Native (1.2 percent). The most prevalent conditions in this population are: hypertension, diabetes, coronary artery disease (CAD) and mental health concerns. Hypertension, as a single condition, is most prevalent among Asian and African American members. Diabetes as a single condition is most prevalent among Asian, African American and Hispanic members. CAD is most prevalent in the other, Asian and Caucasian members. Mental health is most prevalent among Caucasian and Hispanic members.

Provider Network

The HIP provider network offers a comprehensive medical and ancillary delivery system throughout the Medicare service area. HIP contracts with individual providers in primary and specialty care services, in all of the following areas: medical specialists (internal medicine, endocrinology, cardiology, oncology, nephrology, geriatric specialists, pulmonologists, immunologists); behavioral and mental health specialists (psychiatry, drug counselors, clinical psychologists, social workers); nursing professionals (nurse anesthetists, nurse practitioners) and allied health professionals such as physical therapists, occupational specialists, speech pathologists and radiology specialists. HIP also contracts with facilities pertinent to the care of special needs members, including inpatient, outpatient, rehabilitative, long-term care,

psychiatric, laboratory and radiology/imaging. The network also includes diagnostic facilities, laboratories, ambulatory/surgical centers, urgent care and dialysis facilities.

Care Management and Coordination

The health risk assessment (HRA) tool identifies a member's baseline health status by assessing demographics, race, mental health conditions, lifestyle, behaviors, cognitive ability, co-morbid disease conditions, level of self-sufficiency, social interactions, living conditions and environmental factors. The initial HRA is sent to members within 30 days of enrollment. In addition to the initial HRA, an annual reassessment is conducted for each member.

HRA responses are reviewed and stratified to determine where the member can be referred for further outreach, evaluation and the development of an individualized care plan (ICP). Stratification identifies members "at risk", members with selected diseases and members needing or requesting condition-specific services. The ICP is the comprehensive care planning document specific to the member. The primary case manager (CM), who is a nurse, works collaboratively with the member, family, designee, PCP and other multi-disciplinary team members to develop the ICP. The CM evaluates the member's progress and response to the treatment plan at a minimum of every thirty days.

HIP's interdisciplinary care team (ICT) consists of a medical director, the senior director of medical management, the director of utilization management and the director of case management within the respective departments. Additionally, ICTs include physicians, nurses, social workers, complex case managers, transitional care managers, point of care managers and a mental health care specialty team. Other healthcare providers such as pharmacists and nutritionists are involved when necessary. HIP facilitates the participation of beneficiaries and their caregivers as members of the ICT. CMs ask members for input and request their personal goals, objectives and preferences. Just as the ICP is individualized to meet the needs of the member, so is the composition of the ICT. The ICT tracks and shares patient information with providers and monitors patient health outcomes to initiate changes in care, as necessary, to address a member's health needs.

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.emblemhealth.com/Our-Plans/Medicare.aspx.