Elderplan, Inc., H3347
Dual (Full Benefit) Special Needs Plan

Model of Care Score: 75.63%
3-Year Approval **January 1, 2014 – December 31, 2015**

Target Population

The Elderplan Medicare Dual-Eligible Special Needs Plans are designed to provide healthcare to those members who are eligible to receive services under Medicare Parts A and B and who receive additional health care benefits under the New York State Medicaid program. These members reside in the counties of Richmond, Bronx, Queens, Kings, New York, Westchester, Putnam, Rockland, Suffolk, Nassau or Monroe.

Based on members' level of Medicaid eligibility, Elderplan offers members the All Dual Plan, the Medicaid Advantage Plus Plan (MAP) and the Medicaid Advantage Plan (MA). While each of these plans has separate eligibility requirements, the All Dual Plan includes cost-sharing assistance for members eligible for Medicare and full Medicaid benefits.

Provider Network

Elderplan conducts evaluations twice a year and analyzes claim and encounter data to ensure that a sufficient number of board certified practitioners in geriatrics, cardiology, neurology, endocrine, orthopedics, nephrology, pulmonology, and behavioral health along with acute hospitals, rehabilitation and psychiatric facilities and sub-acute nursing facilities participate in the network. It ensures that qualified physicians and nurse practitioners are available to make home visits when the need arises. The plan also ensures the availability of: radiology and laboratory providers, certified home health agencies, licensed home health care agencies, transportation and
DME vendors for community based services. It reviews an inventory of non-participating providers that have performed clinical services in the past to fill any identified gaps.

All members must select a participating primary care physician (PCP) who works closely with the member and ICT to assure the member has access to all necessary primary, secondary and tertiary services. The care manager acts as liaison between the PCP and the interdisciplinary care team (ICT) and will encourage and support the member in conversations with his/her PCP.

Care Management and Coordination

Elderplan uses the Health Status Form (HSF) to assess each member at enrollment and annually thereafter. This self-reported tool identifies members at risk for frailty, acute admissions and key medical, psychosocial, activities of daily living and cognitive issues. It uses elements of the Probability of Repeated Admission (PRA) and the Frailty Risk Assessment (FRA) to generate a risk score using mathematical calculations.

In addition to the HSF, a clinical member of the ICT assesses the member using the NY State Semi-Annual Assessment (SAAM) form either face-to-face or by phone. The SAAM identifies more detailed clinical information, specific activities of daily living and instrumental activities of daily living where members require assistance. Elderplan re-administers the SAAM at six-month intervals.

An enrollment registered nurse develops the initial care plan with member, caregiver and physician support. Subsequently, the ICT team supervisor reviews this information and assigns a care manager, who has access to a variety of clinical guidelines and criteria embedded in the organization's system. The care manager works to develop goals and identify the appropriate interventions, which may include services such as home visits by physicians, telehealth monitoring or palliative care. The care manager elicits member participation in areas such as advance care planning. When the care manager identifies clinical concerns, PCP participation is solicited.

Elderplan evaluates and updates the care plan on a semi-annual basis or when the ICT identifies a significant change in condition or health status. The PCP receives a copy via mail or fax. The individualized plan of care (ICP) is accessible and any member of the ICT can update it.

Each ICT consists of designated nurse care managers, social work care managers and managed care coordinators. Elderplan's registered pharmacists, chief medical officer and physician advisors also consult and contribute to ICT teams. Managed care coordinators provide administrative support. In addition to these employed staff, the plan considers the PCP and other professional providers of care part of the ICT. Elderplan also adds behavioral and/or mental health specialists to the ICT as necessary to meet needs of member.

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://elderplan.org/