Managed Health Inc., H3359
Institutional (Institutional-Facility) Special Needs Plan

Model of Care Score: 97.50%
3-Year Approval **January 1, 2013 to December 31, 2015**

Target Population

Healthfirst is offering a special needs plan to eligible institutional individuals. The target population is individuals who presently are located in a long term facility contracted with the plan, are at the end stage of life, individuals who no longer have the ability to stay in their home or receive comprehensive/coordinated care. Healthfirst will target long term care and nursing facilities that are within the Bronx, Kings, Queen and New York Counties in New York State.

Provider Network

Healthfirst offers the full spectrum of covered healthcare services. Based on the nature of these members' condition, most of their care will be provided within the walls of their resident nursing home. The primary and specialty care providers practice in a variety of settings including hospital, hospital-sponsored and independent community-based practices, private provider's offices, Federally Qualified Health Centers and nursing homes. Healthfirst also contracts with providers that deliver enhanced or specialized services beyond hospital and physician-based care, such as routine vision, dental, chiropractic and pharmacy benefits as well as contracted ancillary providers who provide specialized healthcare services. Due to the special needs and physical location of this population, the provider network partners with nursing homes who not only have broad clinical capabilities, but also have the infrastructure to provide accurate and timely quality reporting as well as clinical oversight within their operational structure.

All members are required to select a primary care physician (PCP) to provide basic care and to assist in coordinating other needed services; however, there are no referral requirements to utilized providers within the plan's provider network.

Care Coordination

Each I-SNP member will receive a complete initial health risk assessment (HRA) using the Minimum Data Set (MDS) 3.0 Nursing Home Assessment Tool and Mini-Mental Status Examination upon admission and/or enrollment by the nursing home clinical staff and monthly thereafter by the Healthfirst care manager. The MDS 3.0 is the Centers for Medicare & Medicaid Services industry-wide assessment tool used by nursing homes to assess the member's health care status, primary diagnoses and activities of daily living (ADLs). The Mini-Mental Status Examination offers a quick and simple way to quantify cognitive function and screen for cognitive loss. Because of the frailty of the population, a proactive monthly assessment will be made on all members by the care manager using the MDS 3.0. Each assessment is performed face to face at the relevant facility where the member resides.

Based on the results of these assessments, all the members are classified into one of the three risk priority levels. The assessment results and the risk priority level are used as the basis for care planning. The individualized care plan (ICP) is developed by the interdisciplinary care team (ICT) in collaboration with the member and/or caregiver. It is based on the initial and periodic assessments of the member's health and functional status. The ICP includes member's relevant clinical history, health status, short and long term goals, timeframe for reevaluation, resources to be utilized, planning for continuity of care and collaborative approaches to be used.

The ICT consists of Healthfirst I-SNP staff (nurse care manager and support coordinator/paraprofessional staff), skilled nursing facility/nursing facility ICT (nursing staff, rehabilitation staff, nutritionist, recreational therapist, social worker, discharge planner, respiratory therapist, physical/occupational/speech therapist, care manager and MDS 3.0 assessor), PCP and specialists involved in the care of the member. The ICT is responsible for finalizing the initial care plan and management of all aspects of care and service delivery. Changes in composition of the ICT are determined by changes in member status. The ICT has monthly care planning meetings to review member reassessments and determine the appropriateness of member's care plan or more often if necessary based on changes in the member status.

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.healthfirstny.org/2014-healthfirst-medicare-plans.html