H3359 Managed Health, Inc.
Dual-Eligible (All Dual) Special Needs Plan

Model of Care Score: 93.33 %

3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Managed Health, Inc. (a part of Healthfirst) dual special needs plan (SNP) enrolls members who are Medicaid eligible individuals and are entitled to Medicare. Members are located in the following counties of New York: Brooklyn, Manhattan, Richmond, Queens, Bronx, Nassau and Westchester. Of the 60,005 members, 27.9 percent are Hispanic, 22.2 percent are Black or African American, 20.2 percent are Caucasian, while the other 23 percent are Asian, Indian or of an unknown race. Most members are female (63 percent) and 52 percent of the members are 70 and older. The majority of members speak Spanish followed by English.

Provider Network

Managed Health's primary and specialty care providers practice in a variety of settings including hospitals, hospital-sponsored and independent community-based practices, private provider's offices and federally qualified health centers. As each member is required to specify a primary care practitioner (PCP), these providers may have specialties in family practice, internal medicine, general practice, geriatrics or pediatrics. Other healthcare professionals in the network include nurse providers/clinical nurse specialists, physician assistants and certified nurse midwives. Other ancillary services include but are not limited to: routine vision, dental, chiropractic and pharmacy benefits as well as behavioral health, dialysis services, skilled nursing care, home health care and home infusion therapy, laboratory services, occupational, physical and speech therapies, durable medical equipment (DME), orthotics/prosthetics and transportation services.

Care Management and Coordination

The health risk assessment (HRA) is completed within 90 days of enrollment and at least annually thereafter and upon significant change in the member's health status. The HRA is a written questionnaire that assesses each member for medical, functional, cognitive, psychosocial, and mental health care needs, as well as level of engagement with the PCP. The initial and annual HRA may be completed by mail, online or by telephone. Responses to the HRA are evaluated using a risk algorithm to determine the member's health risk in order to stratify the member. Through stratification, Managed Health is able to better coordinate care and implement

more relevant care management strategies and interventions to improve clinical outcomes and develop an individualized care plan (ICP).

The interdisciplinary care team (ICT) consists of Managed Health staff, providers and other resources with knowledge and experience to support targeted member needs, goals and expected health outcomes. The ICT membership is developed based on the member's initial and ongoing assessments and dialogue with the member his/her PCP or treating physician. The ICT members may also include a PCP, geriatrician, nurse practitioner, physician's assistant, specialist social worker, registered nurse, restorative health specialist behavioral and/or mental health specialist, dietitian or nutritionist, pharmacist/clinical pharmacist, disease management specialist, nurse educator, pastoral specialist, community resources specialist, caregiver/family member and preventive/health promotion specialist. Changes in composition of the ICT are determined by changes in member status. The case manager (CM) is responsible for the member's care and involvement in the ICT. Communication may be face to face, by phone, written notice or fax.

The essential elements incorporated into the ICP are the results from the HRA and the member health status, including condition-specific issues. Additional elements include identification of barriers and needs, and member specific prioritized goals associated with identification of short and long term goals that serve as a roadmap to achieve desired outcomes. CMs evaluate members' health status to identify health conditions and likely co-morbidities, including whether prevention milestones are due and met and members' functional status related to five activities of daily living: eating, bathing, walking, toileting and transferring. The CM will consult the member or caregiver throughout the development of the ICP and these meetings may occur face to face, by telephone, or in writing and then shared with the ICT.

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