H3359 Managed Health, Inc.
Dual-Eligible (Dual Eligible Subset-Medicare Zero Cost Sharing) 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) has members who are eligible for the New York state Medicaid Advantage program. These members must be 18 years of age or older, live in the service area, have full Medicaid coverage, and must have evidence of Medicare Part A and Part B coverage (or be enrolled in a Medicare Part C program). Almost two-thirds of dual eligibles are over age 65, and more than one-third are under age 65 and have serious disabilities and chronic illnesses. Eighty-eight percent of members in this plan have income that is far below the federal poverty level, more than 54 percent do not have a high school diploma and more than 40 percent have significant behavioral health or cognitive problems. Twenty percent are living in an institution and another 27 percent are living alone. More than 40 percent are of racial or ethnic minorities who speak the several languages other than English and Spanish such as Mandarin, Cantonese, Russian, Korean, and Creole.

Provider Network

Managed Health primary and specialty care providers practice in a variety of settings including hospital 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 could be nurse providers/clinical nurse specialists, physician assistants and certified nurse midwives. Other ancillary services provided include routine vision, dental, chiropractic and pharmacy benefits as well as contracted ancillary providers who provide specialized healthcare services such as behavioral health, dialysis services, skilled nursing care, home health care and home infusion therapy, laboratory services, diagnostic testing, hearing aids, occupational, physical and speech therapies, durable medical equipment (DME), orthotics/prosthetics and transportation services.

Care Management and Coordination

The health risk assessment tool (HRAT) is completed within 90 days of enrollment and at least annually thereafter and upon significant change in the member's health status. The HRAT 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 HRAT may be mailed, completed online, or by telephone. Responses to the HRAT 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 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 as well as the member's PCP or treating physician. The ICT members may also include the primary care physician, 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 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 in the ICP are the results from the HRAT responses and considers the member health status, including condition-specific issues to assist in identification of barriers and needs; member specific prioritized goals associated with identification of short and long term goals that serve as a roadmap to achieve desired outcomes. Case managers 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, transferring. The case manager 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