H4922 AgeWell New York LLC.
Dual Eligible (Dual Eligible Subset - Medicare Zero Cost-sharing) Special Needs Plan

Model of Care Score: 100.00%
3-Year Approval **January 1, 2015 to December 31, 2017**

Target Population

AgeWell New York (AgeWell) Dual Eligible Special Needs Plan serves dual eligible individuals with complex medical and health needs, who can live safely at home. As a whole, members are vulnerable, many are the sickest and poorest of the Medicare and Medicaid beneficiaries in New York State. Members have Medicare Part A and Part B and reside in AgeWell's geographic service area of Nassau, Queens, Brooklyn, Suffolk, Bronx, Manhattan and Westchester. AgeWell covers primary, specialty and acute medical services and Medicaid-covered long term care services. Thirty-nine percent of members are between 75 and 85 years and 24 percent of members are older than 85 years. The top diagnoses among members are hypertension (77 percent), osteoarthritis (55 percent), lipid metabolism disorder (46 percent) and diabetes (40 percent). Thirty-five percent of members are White, 20 percent are Black, 20 percent are Asian or Indian and 15 percent are Hispanic. English is the primary language spoken by 30 percent of members, 25 percent speak Russian, 20 percent speak Chinese and Korean and 15 percent speak Spanish. The majority of members have expressed difficulty walking (94 percent).

Provider Network

The AgeWell provider network includes inpatient, outpatient, rehabilitative, dialysis, long-term care, psychiatric, laboratory and radiology/imaging. Medical specialists include but are not limited to primary care, internists, cardiology, nephrology, psychiatry, geriatric specialists, oncologists, pulmonologists, neurology, gynecology, immunologists, dermatologists and gastroenterologists. Network behavioral and mental health specialists include psychiatrists, drug counselors and clinical psychologists. Nursing professionals include registered nurses (RN), nurse practitioners (NP), nurse managers and nurse educators. Allied health professionals include pharmacists, physical therapists, occupational specialists, speech pathologists, laboratory specialists and radiology specialists. The network also provides members with 24 hour access to a nurse care manager.

Care Management and Coordination

A health risk assessment (HRA) is completed by a RN within 30 days, but not to exceed 90 days after the member's enrollment into the plan, and a semi-annual reassessment within 180 days of the last assessment. The HRA is a combination of several assessments that focus on the medical,

psychosocial, cognitive and functional needs and disabilities of members and it is used to evaluate members' current and future health risks. It also identifies elderly and frail members at risk for increased emergency department visits, hospitalization and skilled nursing facility (SNF) admission and includes a full medication review. After the HRA is completed, the care manager (CM) completes additional assessments with the member, which helps determine the member's risk level. The CM, who is a RN, is responsible for reviewing and analyzing the HRA. Others involved in the review of member health care needs are those involved in the member's interdisciplinary care team (ICT) such as physicians, NPs, pharmacists, psychologists, therapists, specialists and social workers.

Member risk level is determined and an individualized care plan (ICP) is developed based on the information gathered from the HRA. The components of the ICP include but are not limited to: problems and interventions; gaps in evidence-based care; recommendations to the physician; self-care needs, deficits, and services to fulfill needs; psychosocial issues to be followed; issues to be discussed with member and providers; skilled home visit recommendation letter to PCP and level of care, determination and acuity of services. For those members identified as high risk and/or vulnerable, HRAs are performed on a more frequent basis to monitor changes in condition and impacts of interventions. Member ICPs are reviewed and revised by the member's CM, in coordination with the member's primary care practitioner (PCP). All members of the ICT are involved in the development and review of the ICP.

In addition to the member and family/caregivers, the ICT includes the medical director, PCP, specialist(s) as warranted, CM, NP, home and community-based service providers. Additional members can include health educators, health coaches, pharmacists, behavioral health specialists and social workers. The primary purpose of the ICT is to coordinate the delivery of services and benefits that address the member's specific needs in a cost-effective manner. The ICT also communicates with the member, additional providers and caregivers.

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: www.agewellnewyork.com