

**Simply Healthcare Plan, H5471  
Institutional (Facility) Special Needs Plan**

**Model of Care Score: 90.00%**  
**3-Year Approval**

**January 1, 2013 – December 31, 2015**

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**Target Population**

Simply Healthcare Plan's (SHP) Institutional and Institutional Equivalent Special Needs Plan's target population consists of Medicare beneficiaries who are residing in a long term care facility (institutional) and also those residing in the community but have met institutional level of care based on a state-approved assessment (institutional equivalent). Beneficiaries must reside in the SHP service area, be entitled to Medicare Part A and enrolled in Part B and Part D and must not be under treatment for end-stage renal disease (ESRD). The Special Needs Plan (SNP) targets those individuals who reside or are expected to reside for 90 days or longer in a long term care facility (defined as either: skilled nursing facility, nursing facility, or inpatient psychiatric facility). Members are typically over age 65, frail with multiple comorbid conditions and require around-the-clock medical care and daily living assistance.

**Provider Network**

The provider network is comprised of board-certified and board-eligible practitioners and other service providers with specialized expertise in the geriatric and chronically ill population. SHP has successfully worked with primary care practices (PCP) (such as geriatrics, internal medicine, family practice, and general practice), medical (such as nephrologists, endocrinologists, pain management specialists, physiatrists, pulmonologists, neurologists, gastroenterologists, OB/GYNs, hematology-oncologists, urologists, rheumatologists, orthopedists, podiatrists, immunologists) and behavioral health specialists, durable medical equipment vendors, and other providers who share the organization's commitment to bringing decision-making to the member and focusing on home and community-based services.

**Care Management and Coordination**

The health risk assessment (HRA) is a comprehensive questionnaire that evaluates the member's medical, psychosocial, behavioral, cognitive, and functional needs and risks. The HRA addresses important risk indicators such as medication usage, prescribed and over-the-counter, substance abuse/addiction, lifestyle, hospitalizations, transportation, advance directives, and other issues. An initial HRA will be completed within 90 days of enrollment, with an annual HRA performed thereafter. It may be completed over the telephone, face-to-face, or paper-based by correspondence. The HRA information is risk- stratified and will be shared with the interdisciplinary care team (ICT) and care managers electronically or in hard copy. It is reviewed at least annually for its effectiveness.

The individualized care plan (ICP) is developed and implemented to ensure that the interventions and goals are designed to educate and empower the member/caregiver to take an active role in exercising his/her rights and responsibilities concerning his/her healthcare. Each SNP member will have an ICP prepared by the care manager. The Care Managers function as the center of coordination of care

across all settings and providers. They also work in conjunction with the member/caregiver/legal representative, the PCP, and the members of the ICT in the development and on-going updates of the care plan. The ICP will serve as a guide for the care manager, PCP, and other ICT providers, in providing the medical and psychosocial needs of the member.

The ICT is composed of the PCP, ancillary, and specialty care providers pertinent to the member's specialized needs. The ICT will always include at a minimum the member, the PCP and a nurse care manager or nurse practitioner/physician assistant for members. Other members of the ICT may include but are not limited to: social workers, behavioral/mental health specialist, dietician/nutritionist and pastoral services. The ICT is responsible for developing and implementing the ICP. The meetings are based on the member's availability and can be by telephone or face-to-face.

This Model of Care (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 member needs.

For more information about this health plan refer to the Simply Care and Simply Comfort area of the Special Needs Plan's website at: <http://www.simplyhealthcareplans.com/medicare/benefits/>