Metropolitan Health Plan (MHP), H5750
Dual Eligible (Medicaid Subset - $0 Cost Share) Special Needs Plan

Model of Care Score: 90.00%
3-Year Approval **January 1, 2012 to December 31, 2014**

Target Population

The target population of this Special Needs Plan (SNP), Cornerstone Solutions, includes individuals in Hennepin County, MN who are certified as disabled or blind and receive benefits under Medical Assistance. Members may also receive benefits under Medicare Parts A and B. These individuals may have experienced a physical health, mental health or developmental disability or a traumatic brain injury and must be age 18 to 64. Persons who turn age 65 after enrollment have the option of remaining in the program or choosing to receive home and community based services as an Elderly Waiver participant.

Fifty-seven percent of the SNP's members are male and almost half of are between 50 – 65 years of age. Overall, members have complex and chronic illnesses, are predominantly experiencing mental illnesses and chemical dependency and are economically disadvantaged. Many of these members have also experienced homelessness and problems with the legal system.

Provider Network

MHP contracts with an extensive provider network that includes a range of primary care providers (PCPs), physician specialists, major physical rehabilitation providers and facilities. MHP has an open network for behavioral health services, as well as over 200 contracted behavioral health providers with expertise serving persons with serious mental illnesses.

MHP does not have a gatekeeper model; it allows members to work with their medical providers and care coordinator to determine services they wish to receive and to select providers within the network. The care guide assists members with: establishing a primary medical home, obtaining health care services, and accessing social services and community resources such as food shelves, housing resources, and clothing, as needed.

Care Management and Coordination

MHP has developed a standardized health risk assessment (HRA) that addresses medical, psychosocial, functional, and cognitive needs; activities of daily living; medical and mental health history. Care guides meet with the members face-to-face within the first thirty (30) days of enrollment and annually thereafter to complete the HRA.

Based on the results of the HRA, additional assessments maybe indicated including, but not limited to: a mental health assessment that includes a functional assessment of all daily

activities; developmental disabilities screening; a physical disabilities assessment to identify frail members and those with multiple chronic health conditions; a traumatic brain injury assessment to identify needs for supervision while taking into consideration the highest level of independent functioning; and a chemical dependency assessment to review relevant treatment records, screen physically and evaluate for detoxification.

The SNP uses a quadrant model to stratify members that enables a focus on the high prevalence of co-occurring disorders for adults with disabilities. The quadrant model provides an overview of who is involved with a member, the tasks they perform, and where they work together. It outlines interventions, problems, strengths, goals and objectives including long-term and short-term goals.

The care guide also works with the member, whenever feasible, and the interdisciplinary care team (ICT), to establish an individualized care plan (ICP), which addresses all areas of concern identified on the HRA. The ICP includes demographic information, member strengths and needs, preventive health care, oral health, chemical health, mental health; maintaining Medicaid eligibility, social services, recreational, cultural, educational and vocational needs, as well as informal and caregiver supports and input, as applicable. In addition, the ICP has measureable goals, interventions, timeframes and member or responsible party signatures.

Care guides continually monitor member's health status and implementation of the member's ICP, which are reviewed and updated every 180 days or more frequently, if the member experiences a transition in care, sentinel event or significant change in health status.

The ICT consists of the member or responsible party, PCP and other service providers and supports included on the member's care plan. The exact composition of each ICT is based on the needs and preferences of the member or representative. Types of providers that could serve on the ICT include: a nurse practitioner, physician's assistant, social worker or community resource specialist, a registered nurse, a physical, occupational or speech therapist, a behavioral health specialist, a dietician, a disease management specialist and a preventive health/health promotions specialist.

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 beneficiary needs.

For more information about this health plan refer to the Special Needs Plan's website at: www.mhp4life.org