Affinity Health Plan, H5991
Dual Eligible (All Dual) Special Needs Plan

Model of Care Score: 94.38%
3-Year Approval **January 1, 2014 to December 31, 2016**

Target Population

The target population for Affinity's Medicare Solutions Plan and its Ultimate Plan consists of members with full or partial Medicaid benefits from the State of New York, who reside in the following counties: Bronx, Kings, New York, Queens, Richmond, Nassau, Orange, Rockland Suffolk and Westchester. Those with partial Medicaid benefits receive assistance with Medicare Part B premiums. Both plans tend to have a younger disabled population. The average age of members in the Solutions plan is 64 and 63 in the Ultimate Plan. The top two primary diagnostic categories for Affinity's members are diabetes and hypertension but they also have many chronic conditions and multiple co-morbidities such as: heart disease, pulmonary disorders, or vascular disorders. The plan's members are especially vulnerable due to their lower socio-economic status, prevalence of chronic conditions, disabilities, and issues with accessing appropriate health care services.

Provider Network

Affinity works to minimize barriers to appropriate care by ensuring its provider network reflects diversity in culture, ethnicity and primary language. The plan instructs primary care physicians (PCPs) of the critical role they play in the coordination of quality care for members. It also gives special priority to ensuring that the provider network includes specialists in cardiology, nephrology, psychiatry, geriatrics, pulmonology and immunology who are able to treat diabetes, hypertension and related conditions. Affinity contracts with inpatient, outpatient, rehabilitative, long-term care, psychiatric, radiology/imaging facilities and laboratories as well as nurses and allied health professionals. In addition, members can also access a variety of services in Federally Qualified Health Clinics (FQHC).

Care Management and Coordination

Customer service advocates (CSAs) perform initial assessments within thirty (30) calendar days of the member's effective date using an assessment tool that measures members' physical and mental health. A delegated vendor conducts an annual reassessment by phone for all members. The vendor employs registered and licensed practical nurses with expertise in patient engagement and interviewing techniques to conduct health risk assessments (HRA). Findings from the HRA directly impact the provision of care management and recommended interventions

for members. Case managers use the HRA score to group members into a high, medium or low case management category.

The case manager utilizes the results of the HRA and other reports to develop an individualized care plan (ICP) with the member/caregiver, PCP, appropriate specialists and other interdisciplinary care team (ICT) members.

Care plan activities may include: coordination of referrals and authorizations for home health services or outpatient therapies; identification of clinical parameters appropriate for a member's diagnosis (e.g., HbA1c every 6 months for diabetics); identification of gaps in care for these indicators based on a medical claims profile; health education; nutritional counseling; self-management goals and activities; education regarding available benefits; and coordination of transportation, personal care services or home delivered meals. The ICP also includes any barriers to achieving the goals, such as financial concerns, cultural constraints and the lack of family support. The case manager works with the member to develop strategies to address these barriers where possible.

Case managers reference the ICP periodically and make necessary revisions to it. The ICT reviews all care plans annually, following a change in health status, or as necessary.

Affinity assigns each member to an ICT and the purpose of this is to foster regular, structured, and documented communication among disciplines to establish, prioritize and achieve care plan goals.

The ICT is composed of clinical and non-clinical staff and the plan selects core participants based on the medical, behavioral, financial and social needs of its membership. Team members have current knowledge of the member's history as documented by claims and utilization data, assessments and other documentation in Affinity's system. When a member's medical, behavioral or psychosocial needs warrant additional expertise, other disciplines may join the core participants in reviewing and recommending changes to the care plan goals.

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.affinityplan.org/Plans/Medicare/Affinity_Medicare_Advantage.aspx