H8189 Managed Health Services, Wisconsin
Dual Eligible (Full Benefit) Special Needs Plan

Model of Care Score: 85.00%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Managed Health Services, Wisconsin (MHS) is a Dual Eligible Special Needs Plan (D-SNP) that targets members who: are enrolled in Parts A, B and D of Medicare, eligible for full Medicaid benefits, reside in one of its service areas and do not currently have end-stage renal disease. MHS is located in the following 27 counties: Adams, Brown, Calumet, Kenosha, Kewaunee, Langlade, Lincoln, Marathon, Marinette, Marquette, Menominee, Milwaukee, Oconto, Outagamie, Ozaukee, Portage, Racine, Shawano, Sheboygan, Taylor, Washington, Waukesha, Waupaca, Waushara, Winnebago, Fond du Lac and Wood. .

Of the 1,035 dual-eligible enrolled in MHS, females outnumber males (57 percent to 43 percent) and the majority of members (49.86 percent) are age 55 or older. The top four diagnoses within the population include: neurology (14.4 percent), diabetes (9.4 percent), joint degeneration/inflammation (5.5 percent) and cardiology (4.7 percent).

Provider Network

Members have access to a wide range of credentialed and contracted providers that include physicians with specialties in: cardiac care, orthopedics, rheumatology, allergy, urology, dermatology, pathology, pulmonology, optometry, endocrinology, podiatry, neurology, hematology, gastroenterology, obstetrics, gynecology and oncology. The network also consists of: nursing specialists that include nurse practitioners and physician assistants; rehabilitative/restorative therapy specialists that include physical, speech and occupational therapy; oral health specialists that include dentists and oral surgeons; mental health specialists; pharmacists and medical equipment suppliers. In rare instances when in-network services are not available, the interdisciplinary care team (ICT) coordinates members' access to out-of-network providers.

The types of facilities included in the network encompass: hospitals and emergency departments, urgent care centers, outpatient care centers, long-term care hospitals, laboratories, skilled nursing facilities, federally qualified healthcare centers, rural healthcare centers, pharmacies, radiography facilities, rehabilitative facilities, dialysis centers, outpatient surgery centers, hospice, home health agencies and infusion centers.

Care Management and Coordination

Within 90 days of enrollment and annually thereafter, a case manager (CM), program coordinator (PC) or member representative (MR) conducts an initial health assessment/risk stratification (HRA) by telephone with each member. The HRA identifies the member's medical, psychological, functional and cognitive needs. The assessment also gauges the member's medical and behavioral health history to coordinate his or her care. Based on the member's risk stratification score, he or she receives a referral to a RN case manager (high, moderate and low risk members with clinical needs) or a program specialist/social worker (low risk members who do not have clinical needs but who require care coordination).

The interdisciplinary care team (ICT) creates an individualized care plan (ICP) based on the HRA results and information obtained from the member, his or her caregiver and providers involved in the member's care. The essential elements of the ICP include: in-depth information about the member's health/functional status, prioritized goals with measurable outcomes, barriers to meeting the goals or complying with the ICP, case management activities and/or interventions to accomplish the goals and a self-management plan. The CM performs on-going assessments to evaluate the member's progress toward the goals and/or identify barriers impeding goal achievement. The CM completes a reassessment annually, at a minimum, and whenever the member experiences a significant change of condition.

A board certified medical director leads the ICT, which includes: CMs, social workers, behavioral health care managers, PCs, MRs and pharmacists. As identified in the HRA and pertinent to the member's health care needs, the following providers may also participate in the ICT: a primary care physician, specialty care physicians, nurse practitioner, mid-level practitioner, a registered nurse, occupational/speech/physical therapists, a dietician, a health educator, a disease manager, a behavioral/mental health specialist, a community resources specialist, a dentist and faith-based representatives. The ICT reviews members' progress during its thrice-weekly management review rounds, or depending upon the member's needs.

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://advantage.mhswi.com/.