AlphaCare of New York, INC, H9122
Institutional (Facility) Special Needs Plan

Model of Care Score: 78.13%
2-Year Approval **January 1, 2014 – December 31, 2015**

Target Population

This plan's target population is Medicare beneficiaries residing in long-term care facilities in the following New York Counties: Bronx, New York, Queens and Kings. They must reside in either a skilled nursing facility (SNF) or a nursing facility (NF) for 90 days in order to be eligible for the program. The plan will focus on early identification and treatment of medical problems, treating the member in their own "home" whenever feasible, and providing care coordination between the member, facility, caregiver and physicians.

Provider Network

The provider network is being built to provide specialized expertise to address institutionalized members' medical, behavioral, cognitive, functional and supportive service needs. The plan brings services to the facility where members reside as many are confined to a facility and cannot access them in the community. There is a network of skilled and non-skilled nursing homes where members reside as well as acute care hospitals with inpatient rehabilitation and behavioral health centers, long term acute care centers and ambulatory surgery centers. The network also includes oncology clinics for chemotherapy administration and dialysis services.

Primary care physicians (PCP) are on staff at the contracted skilled nursing facilities, including geriatricians, family practice and internal medicine physicians. The plan also uses physician assistants and nurse practitioners to assist with care management. The network includes specialists from various disciplines to address the range of members' chronic conditions. Allied professionals such as nutritionists, psychologists, respiratory therapists and social workers are also available, as is hospice for terminally ill members. The plan contracts with transportation vendors to provide non-emergency transport via wheelchair or gurney to members that need to obtain care outside the facility.

I-SNP members are required to select a PCP when they enroll. The PCP coordinates preventive care and treatment of illnesses within the scope of their practice. The PCP is responsible for coordinating and monitoring member care when multiple providers are required to treat the member.

Care Management and Care Coordination

All members receive an initial health risk assessment (HRA) conducted onsite at their nursing facility by a nurse practitioner within 90 days of enrollment. The plan uses a standardized assessment required by New York State. It addresses members' health, functional, mental health and cognitive status as well as social supports, medications and transportation needs. The plan, in consultation with the member's PCP, uses the results to determine members' level of need, care plan development and referrals for clinical and social services. Members are stratified as high, moderate or low risk, with the most vulnerable prioritized for appropriate care management interventions.

In conjunction with the member or their responsible party, the facility and the member's PCP, the plan's care managers develop an individualized care plan (ICP) to meet that member's specific needs. The ICP may include short and long-term goals, self-management goals, if applicable, resources or benefits needed for care, coordination of Medicare and Medicaid benefits, identification of measurable goals (e.g., weight loss, BP rates) and potential barriers to achieving identified goals. The ICP also addresses how to include member and family participation and education. The care manager works with the member and the nursing facility staff to develop strategies to overcome barriers and achieve member goals, including medical and social issues that may have an impact on members' quality of life. Care plans are reviewed annually and more frequently if needed because of issues such as a change in health status or hospitalization.

The plan utilizes an interdisciplinary care team (ICT) to review member care plans and recommend changes, if appropriate. The core members of the ICT are selected based on the overall needs of the plan's I-SNP population, including medical, behavioral health, financial and social issues. The core team includes the chief medical officer, supervisor of pharmaceutical services, social workers, nurse care manager (for member) as well as other practitioners that may be involved in the member's care.

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://www.alphacare.com/