

**AlphaCare of New York, INC, H9122**  
**Dual Eligible Special Needs Plan (D-SNP)**

**Model of Care Score: 78.13%**

**2-Year Approval**

**January 1, 2014 – December 31, 2015**

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**Target Population**

This plan's target population is Medicare beneficiaries in the following New York Counties: Bronx, New York, Queens and Kings. Accordingly the *New York State Medicare-Medicaid Profile* reports there are 739,000 Medicare-Medicaid enrollees in New York, representing 4% of the state's entire population. Dual-eligibles represent 25% of the state's Medicare population and 15% of its Medicaid population. Nearly ½ reside in Brooklyn and Queens and 76% are over the age of 65. Current U.S. Census Data, New York City's over-65 population has a high rate of ethnic diversity, with 40% non-white and 18% Hispanic overall. Within New York City, Brooklyn and the Bronx are the most racially diverse. 37% of the Bronx elderly are Hispanic and 54% are non-white. In Brooklyn, 43% are non-white. Queens County contains the largest ethnic diversity with the highest number of foreign languages spoken of any county in the entire nation. Income levels and poverty rates vary significantly in the service area with the City's overall median household income for people over 65 at \$29,500. The Bronx and Brooklyn fall below that level, with higher rates of poverty among the elderly (21%–22%). Moderate to high poverty rates exist in northern Manhattan, the South Bronx and parts of Brooklyn and Queens.

The member profile underscores the complex medical and psychosocial needs of this population. It further indicates members generally have greater health and long-term services and support needs than beneficiaries who have only Medicare or Medicaid coverage. Dual eligible beneficiaries living in New York typically have a greater prevalence of chronic conditions with the following being most prevalent: Heart Disease, Diabetes, Depression and Congestive Heart Failure.

**Provider Network**

The AlphaCare provider network is designed to provide specialized expertise to effectively address the D-SNP member's medical, behavioral, functional and supportive service needs. The network includes facility services such as acute care hospitals, inpatient rehabilitation, behavioral health centers, skilled nursing facilities and ambulatory surgery centers. Other facility services such as oncology clinics, dialysis centers, outpatient rehab, lab and radiology services are also included in the network.

Primary Care Physicians including Family Practice, Internal Medicine and Geriatricians. Experienced midlevel practitioners such as physician assistants and nurse practitioners are also part of the contracted primary care network. A full panel of specialists from various disciplines is represented in the network to address the most common chronic diseases and allied professionals such as nutritionists, psychologists, and social workers.

## Care Management and Care Coordination

All members receive a face-to face Health Risk Assessment (HRA) conducted by an AlphaCare Care Manager within 30 days of enrollment. The HRA form includes information in the following general categories: clinical history, care utilization, functional status, including pain assessment, mental health, cognition and psychosocial issues/supports, living arrangements, health promotion and screening, medications, transportation and durable medical equipment (DME) needs.

AlphaCare utilizes an Interdisciplinary Care Team (ICT) to review member care plans and recommend changes, if appropriate. The core participants of the ICT are selected based on the overall needs of the plan's D-SNP population which include medical, behavioral health, financial and social issues. The core team will be comprised of the following members: Chief Medical Officer, Supervisor of Pharmaceutical Services, Social Worker, and a RN Care Manager and based on unique member cases being reviewed by the ICT, other contracted and non-contracted practitioners involved in the member's care may be asked to participate in ICT meetings. The Care Manager is responsible for determining the need for additional participants such as (PCPs), medical specialists, nutritionists, clergy, home health nurses and other community supports.

Individualized Care Plans (ICP) are developed from the analysis of the initial and annual HRA (unless the member's condition changes to warrant an assessment prior to the annual), incorporates input from various appropriate sources. In conjunction with the member/RP, the facility and the member's PCP the AlphaCare Care Managers develop a Care Plan individualized to that member's specific needs. The ICP may include, but not be limited to, the short and long-term goals, self-management goals, resources/specific benefits to be utilized, including the appropriate level of care, collaborative approaches, including family participation, educational materials and potential barriers.

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>