Gateway Health Plan of Ohio, H9190
Chronic or Disabling Condition
(Cardiovascular Disorder, Chronic Heart Failure and/or Diabetes)
Special Needs Plan

Model of Care Score: 90.00%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

Gateway's target population is comprised of vulnerable members with cardiovascular disorders, chronic heart failure, and/or diabetes. Sixty-eight (68) percent of the population are disabled and 32 percent are aged; the average age is 47 for disabled members and 74 for aged members. Gateway will operate in 36 counties in Ohio and 16 counties in North Carolina.

Provider Network

Gateway's provider network includes facilities, pharmacies and providers having specialized clinical expertise pertinent to the Gateway population. Contracted facilities not only include skilled nursing facilities, specialty clinics, inpatient hospitals and ambulatory surgical centers, they also include behavioral health inpatient and outpatient facilities. Providers include Primary Care Physicians (PCP), medical specialists, mental and behavioral specialists, nursing professionals, rehabilitation/restorative therapy specialists, pharmacists and clinical pharmacists, allied health professionals and social worker/social services professionals. In addition, all members are encouraged, but not required, to coordinate care through their PCP and each member is assigned a PCP upon enrollment. However, members can changes their PCP at any time.

Care Management and Coordination

At the time of enrollment, all new members are sent a one-page Health Risk Assessment (HRA) that consists of five questions and a postage paid envelope. The HRA asks members questions pertaining to their medical and psychosocial needs. It provides an initial evaluation of the member's overall health and determines if the members need further assessment. When members need further assessment or are referred to the care management by other sources, care managers (CMs) complete a more comprehensive HRA called the BEEMSS assessment to determine the level of care needed. It is an evaluation of the member's medical, behavioral, economic, environmental, spiritual and social health status. HRAs are completed annually.

The member's HRA is used to determine the member's level of needs. The levels of needs are stratified into:

- General population – members who do not trigger for additional needs on their HRA or those who decline participation into Gateway's Care Management Program
- Standard acuity – members who have completed the HRA and have identified needs related to specified disease states such as asthma, diabetes, congestive heart failure and coronary artery disease
- Moderate acuity – members who referred to care management and require more frequent interventions by care management staff
- Complex/High acuity – members who are identified as having serious life-impacting disease, such as cancers with metastases, Stage IV heart disease, symptomatic HIV/AIDS, chronic obstructive pulmonary disease, spinal cord injury with residual deficits and traumatic brain injury with cognitive deficits and require frequent interventions from their CM.

The interdisciplinary care team (ICT) is responsible for developing the care plan for members who require general population and standard acuity level of care. The determination of the member's ICT is based on the member's level of needs as assessed on the HRA. However, all levels of care include the member and/or caregiver and PCP. Members who are deemed appropriate for ongoing care management are assigned to a CM, and the CM becomes part of these members' ICT and develops the care plan. The level of care required for these members are moderate acuity or complex/high acuity.

The care plan is revisited at least annually to account for changes in the health needs of the member based on the member's reassessment or if the member is identified as having a health status change that requires him or her to be reassessed. In addition, ICT case reviews are held with an assigned medical director at scheduled intervals to review the member's medical and psychosocial concerns and care plans are updated as needed to account for the changes.

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.MedicareAssured.com.