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

Model of Care Score: 96.67%

1-Year Approval[1] **January 1, 2015 – December 31, 2015**

Target Population

Gateway Health Plan is a chronic condition special needs plans (C-SNP) which limited enrollment to members entitled to Medicare Part A, enrolled on Medicare Part B and Medicaid state programs, who reside in Gateway's service area. To be eligible, a member must have at least one of the following medical conditions: diabetes, cardiovascular disorder, and/ or chronic heart failure. Membership is comprised of those managed for the above chronic conditions including those who are at high risk such as frail, disabled, near the end of life, have end stage renal disease (ESRD) and multiple complex chronic conditions. Membership consists of both disabled and aged members. Disabled members were 34% of the membership with an average age of 56 and aged members consisted of 64% with an average age of 72. Approximately 51% of members are female.

Provider Network

The Gateway Health Plan network includes facilities, pharmacies and providers having specialized clinical expertise pertinent to Gateway's chronic care population. Providers include primary care providers (PCPs), medical specialists (cardiologists, neurologists, surgeons, etc.), mental and behavioral specialists (psychiatrists, drug counselors, clinical psychologists, etc.), nursing professionals, rehabilitation/restorative therapy specialist pharmacists and clinical pharmacists, allied health professionals and social worker/social services professionals. Network facilities include acute care, laboratories, pharmacies, radiography/imaging, long-term acute care, rehabilitation, specialty outpatient clinics and skilled nursing facilities.

Care Management and Coordination

The health risk assessment tool (HRA) is mailed out to the member within 10 days of enrollment and performed annually thereafter. The HRA is used to assess the member's self-identified medical, behavioral health, psychosocial, cognitive and functional needs. The HRA provides an initial and annual evaluation of the member's overall health and needs by assessing common medical issues, medication compliance, access to providers, and ability to perform activities of

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[1] Per CMS guidance, all plans that undergo the Cure process are limited to a one year approval, regardless of the final score.

daily living (ADLs)/instrumental ADLs (IADLs). The HRA includes questions about medical diagnoses and improving healthy behaviors. It also includes questions regarding pain, memory, falls, language, activity level in the home, advanced directives and depression symptoms. The HRA is used to help develop the individualized care plan (ICP) for the member and shared with the interdisciplinary care team (ICT).

The ICT, a group of clinical staff and network providers is selected based on the member's medical and psychosocial needs, degree of self-determination and the team member's ability to impact any identified deficits or barriers. Based on the level of care determined by the HRA and other risk stratification information the member's ICP is developed and the composition of the ICT is determined. The ICT for Gateway members depends on their acuity level and can include the member and/or caregiver, the member's PCP, specialists (e.g. cardiologist), medical director, psychiatrist, behavioral health ICT coordinator, and contracted vendors. It also consists of Gateway Medicare care management staff including the care managers, outreach staff and information technicians, disease management specialist, member services department, pharmacy department, and utilization management department. The care manager invites and encourages the member to actively participate in the ICT meeting, and proactively provides the ICT members with an electronic summation of the member's medical and behavioral health history and needs, as well as, the member's psychosocial concerns.

Each Gateway member has an ICP which is based on care management department services and the member's level of care acuity that targets specific member goals and objectives to maintain or improve their health. There are four major components of the ICP. First, preventive health, which focuses on health and wellness through the use of proactive educational materials and preventive health reminders. The second component is Gateway To Lifestyle Management (GTLM) a comprehensive diagnoses-based disease management program that addresses the needs of members with targeted chronic health care conditions. The third component is for members who have a primary behavioral health diagnosis. These members have had a significant treatment history, including psychiatric admission, and receive specialized care management services. And lastly, complex case management, which is a care coordination program that emphasizes patient education, self-management, supportive counseling, collaboration with providers, and more intensive care management to individuals identified as the most vulnerable members. The ICP is available to the ICT, the member's PCP or specialist and also the member.

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 member needs.

For more information about this health plan refer to the Special Needs Plan's website at: www.MedicareAssured.com.