Windsor Health Plan, H5698
Dual Eligible (Medicare Zero Cost Sharing) Special Needs Plan

Model of Care Score: 91.88%
3-Year Approval **January 1, 2013 – December 31, 2015**

Target Population

Windsor Health Plan's (WHP) population consists of a high rate of beneficiaries with incomes at or below the Federal poverty level, disabled beneficiaries and beneficiaries with educational levels less than high school graduation. In order to address the special needs of the above beneficiaries, WHP, in accordance with its contracts with the state Medicaid agencies, may enroll beneficiaries into its Dual Eligible SNP from all or some of the following categories: Full benefit dual-eligible, Qualified Medicare Beneficiaries (QMB), Qualified Medicare Beneficiary Plus (QMB+), and Specified Low-Income Medicare Beneficiary Plus (SLMB+) into this program.

Provider Network

WHP is an integrated healthcare delivery system that consists of major urban medical facilities, many of which are teaching institutions, a full range of primary care and specialist physician providers, ancillary services, and providers of supplemental benefits. WHP has certain members that may require medical services in the home via a physician home assessment program or visiting nursing services to supplement their regular provider visits. In addition, Windsor has well-established relationships with a full-service home health care vendor network to facilitate any home health or durable medical equipment-related needs. Members can choose a primary care physician or nurse practitioner from the WHP network who serve as the gatekeeper.

Care Management and Coordination

New enrollees in the special needs plan are mailed a health risk assessment (HRA) tool as a part of the member welcome materials. The HRA tool captures the following self-reported data which include demographics, screening and preventive services, health and clinical outcomes (medical and mental history, current health conditions, function, cognitive level), quality of life, medical utilization, life style behavior (nutrition, smoking), current ancillary health services, psychosocial, power of attorney and advance directive. Paper HRAs are sent to the member at the time of enrollment and must be completed within 90 days. Members also have the option to complete a telephonic HRA. HRAs may be updated on an ongoing basis dependent on the members needs and performed annually thereafter.

WHP's interdisciplinary care team (ICT) members work with the member/caregiver and physician to create an individualized care plan (ICP) that is specific to the needs of the member and mitigate any risks identified. The member and/or caregiver are contacted by the care manager to perform a comprehensive and when appropriate condition specific assessment for identification of problems. Care plans are based upon the beneficiary assessment, beneficiary's

medical history, claims, authorizations, member's current health status, the information from their HRA submission, their personal healthcare preferences, benefits, available community resources and on nationally recognized standards of practice. Members and caregivers are educated on the importance of participation in the development of the care plan.

The ICT composition consist of health professionals and service professionals with diverse training and backgrounds, who work collaboratively with the member and/or caregiver in the development of the ICP. The team is comprised of primary care physicians (PCPs), specialists, members, family member/care givers, pharmacy staff, WHP's member navigators and chief medical officer, and care management registered nurses. Other disciplines are called into the ICT as necessary. The care management staff, together with the enrollee and/or the caregiver and the enrollee's personal physician, are the key contributors to the development and implementation of the ICP. The ICT meet at least three times a week. The leaders of the ICT are the WHP medical director in cooperation with the senior manager of care management. The care manager has the responsibility of coordinating any specialized services with the PCP and other specialists based on ICT recommendations. These recommendations are documented in the ICP.

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: http://www.windsorhealthplan.com/Members