Florida Health Care Plan, Inc. H1035
Dual Eligible (All Dual) Special Needs Plan

Model of Care Score: 85.63%
3-Year Approval **January 1, 2014 to December 31, 2016**

Target Population

The Florida Health Care Plan (FHCP) Care Navigator program is designed to serve dual eligible members in all Medicaid eligibility categories. The service area for this program is Volusia County, Florida.

Currently dual eligible members total 6.7 percent of the plan's Medicare Advantage (MA) members. Females comprise 73 percent of these members, while males comprise 27 percent. 35 percent of this population is between the ages of 65 and 74, 37.6 percent are between the ages of 75 and 84 and 27.4 percent are 85 and above.

Based on claims data, the top conditions reported for FHCP's dual eligible members include chronic kidney disease, coronary artery disease, osteoarthritis, diabetes, cancer, cataracts, hypertension, COPD, low back pain and arrhythmias such as atrial fibrillation. The plan expects the profile of the SNP population in Volusia to be similar to that in its existing MA plan.

Provider Network

FHCP's fully integrated delivery system gives members access to preventive and primary care, specialty care, acute, post-acute rehabilitation and skilled nursing services. The system is primarily composed of FHCP employed and contracted providers who provide a full-range of services with specialized clinical expertise pertinent to the dual eligible population.

The plan also has a network of home and community-based service providers who offer homemaker, chore services, meals on wheels, and adult companion services, which enable members to stay in their home.

Care Management and Coordination Summary

FHCP screens members using a validated health risk assessment (HRA) tool that includes health history and captures medical, psychosocial, functional and cognitive input. An initial HRA is completed within 30 calendar days of enrollment and annually, thereafter. The initial contact will involve an in-person or telephone outreach, followed by a mailed version.

Determining members' physical, mental, and behavioral health needs enables the interdisciplinary care team (ICT) to provide education and support for healthy lifestyle choices, affordable housing options, durable medical equipment, long term care placement options, substance abuse or mental health treatment plans, and assist the vulnerable and address unmet needs for food, clothing and shelter.

The care navigator uses information from the HRA, medical records, member and caregiver input, primary care physician (PCP) visits, utilization reports and predictive modeling risk scores to establish an initial stratification level and develop a plan of care.

The member or caregiver, PCP, care navigator and other members of the ICT discuss and agree on goals for the member's care plan. These goals are member-specific and designed to increase function, improve quality of life or improve health status. Care navigators, the PCP and other ICT members collaborate to discuss the member's progress toward goals and changes to the care plan.

The PCP, staff and care navigator subsequently implement the care plan by referring the member to providers, disease management programs, primary or specialty care, or other resources as indicated in the care plan. The care navigator communicates with the member and providers per an agreed-upon follow-up schedule, follows a defined process for members experiencing a care transition and performs periodic assessments of the member's progress toward achieving goals and overcoming barriers to care. The care navigator reviews the care plan with the member every six months and adjusts the goals and the care plan as needed. The care navigator also sends the PCP and the member a copy of the revised care plan when changes are made.

The ICT consists of the member or caregiver, PCP, care navigator and community resource coordinator. Core members may invite other resources to participate in the ICT. The ICT assesses needs, develops, implements, monitors and updates a care plan that is based on member choices and preferences along with ICT recommendations.

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.fhcp.com/