Coventry Health Care of Florida, Inc. H1076
Dual Eligible (All Duals) Special Needs Plan

Model of Care Score: 85.00%
3-Year Approval **January 1, 2012 to December 31, 2014**

Target Population

Currently 78% of Coventry's Special Needs Plan (SNP) members are over 65 years old and 61% are females. Overall 36% of the members are Full Medicaid recipients (MS), 34% are Qualified Medicare Beneficiaries (QMB) and 15% are Specified Low Income Medicare Beneficiaries (SLMB). The four most prevalent diseases within the target population include: diabetes, behavioral health conditions, congestive heart failure and CAD/atherosclerosis.

Provider Network

The SNP's panel of participating providers includes all major specialties and services such as: hospitals and medical centers, laboratories, long term care and skilled nursing facilities, pharmacies, radiological facilities, rehabilitative facilities, primary care providers, home health service providers, behavioral health specialists, dentists/oral health specialists and dialysis facilities. Additional services include specialized clinical expertise and medical specialists including cardiologists, nephrologists, pulmonologists and in areas of disease management, wound care, pharmacotherapy consultation and management, home safety assessments, fall prevention, wellness promotion, palliative and end of life care.

The primary care physician (PCP) is the gatekeeper and responsible for identifying the needs of the member. Coventry and its provider network work together to ensure that members have access to the necessary services.

Care Management and Coordination

The SNP designed the health risk assessment (HRA) tool to identify key member care needs. Coventry staff may administer the HRA via face-to-face interview, by phone, or by self-report on paper within 90 days of enrollment and an annual reassessment within 12 months of the anniversary date of the last assessment. In addition, it conducts a reassessment for flagged health status changes (either clinical or self-reported) and uses the results to update the individualized care plan (ICP).

HRA data, converted into the form of a care plan, narrates, dictates and communicates the member specific stratification, problems, goals, interventions and outcomes. The nurse case manager, in conjunction with the member, assesses the completed HRA tool, initiates the care plan and works with the interdisciplinary care team (ICT) to develop the ICP. The care plan reflects stratified needs that are matched to services and benefits so that the vulnerable and sickest members receive care proportionate to their needs. They also identify standard and add-

on benefits and services required by frail/disabled members and members near the end of life. The team develops, implements and revises (as needed) an ICP with the member/caregiver.

The care plan is considered dynamic, with the expectation of change and modification as each member's condition changes. It identifies: individual care and treatment goals that are realistic, measurable and includes a time frame for achievement, objectives, measurable outcomes and any barriers to achievement, services, care and connects the member/caregiver with add-on benefits and services. The nurse case manager follows up on interventions and monitors service needs on an ongoing basis through member assessment and communications with the member, PCP and SNP staff through the ICP.

Coventry assigns an ICT to each member. ICT composition is determined by the needs of the member. Minimally the team consists of a physician, usually the PCP, social services specialist, pharmacist, nurse case/disease manager and behavioral health services specialist to assure that members' medical, functional, cognitive, and psychosocial needs are considered in care planning. The SNP adds other disciplines as appropriate to meet the member's needs. The member and/or caregiver are included in the interdisciplinary care team.

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://coventry-medicare.coventryhealthcare.com/coventry-health-care-of-florida/index.htm