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

Model of Care Score: 86.67%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Coventry Health Care of Florida, Inc. (CHCFL) is a Dual Eligible Special Needs Plan (D-SNP) for members who are entitled to Part A, enrolled in Part B of Medicare and eligible for Medicaid. These members must also reside in one of its service areas in Broward, Miami-Dade and Palm Beach counties.

The majority of the population consists of females over the age of 65. Sixty-seven percent of members have incomes below the federal poverty level (FPL) and 17 percent of members have incomes between 100-120 percent of the FPL. The two languages most preferred by members are English (77.77 percent) and Spanish (21.63 percent).

Provider Network

CHCFL's providers have the ability to care for the complexities of the D-SNP population including the most vulnerable members who may have multiple, severe, chronic conditions, long-term care needs or cognitive/mental impairment. In addition to primary care practitioners (PCPs), providers with clinical expertise include geriatric specialists, cardiologists, nephrologists, psychiatrists, immunologists and pulmonologists. Members have access to home health service providers; behavioral health specialists (e.g. drug/alcohol counselors, clinical psychologists); dentists/oral health specialists; nursing professionals (e.g. nurse practitioners, registered nurses, nurse educators and nurse managers); and allied health professionals (e.g. pharmacists, physical and occupational therapists and speech pathologists).

The network also includes practitioners capable of providing wound care, pharmacotherapy consultations and management, home safety assessments, fall prevention education, wellness promotion, palliative care and end-of-life care. Additionally, the plan's network encompasses hospitals and medical centers, behavioral health facilities, laboratories, long-term care and skilled nursing facilities, pharmacies, radiological and imaging facilities, rehabilitative centers and dialysis facilities.

Care Management and Coordination

Within 90 days of enrollment and annually thereafter, members complete a comprehensive, health risk assessment (HRA) by phone, mail or face-to-face during a home visit with a social worker. The HRA functions as a clinical roadmap of the member's medical, physical, cognitive, psychosocial and functional needs. The member's risk stratification level determines the intensity of interventions, frequency of reassessments and the level of involvement by the nurse case manager (NCM) in care coordination.

The NCM, in conjunction with the interdisciplinary care team (ICT), use the member's HRA results, medical history, healthcare preferences, pharmaceutical profile, lab results, claims data, current clinical diagnostics and other assessments in the development of the individualized care plan (ICP). Each member's ICP: identifies realistic and measurable goals that reflect his or her unique needs, includes a time frame for goal achievement, identifies services needed to meet the goals and connects the member and/or caregiver with add-on benefits and services. The ICT revises the ICP to reflect changes in the member's needs, progress towards goals, response to care and treatment and/or significant changes in the his or her status, such as care transitions.

At a minimum, the ICT consists of the PCP, a social services specialist, a pharmacist, a nurse case/disease manager and a behavioral health services specialist. Ad hoc participants in the ICT may include: specialists, nurse practitioners, restorative health specialists, a dietician, a nutritionist, pastoral care, palliative care and home care as needed. The ICT convenes on a biweekly basis by telephone, in-person or through web-based meetings to discuss the member's progress. The NCM enters all documentation and ICT recommendations into the electronic case management documentation system. Between meetings, the NCM updates the member's ICP and maintains communication with key participants by phone, email, fax and/or written correspondence.

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