H2667 COVENTRY HEALTH CARE OF MISSOURI, INC

Dual-Eligible Medicare Subset Special Needs Plan

Model of Care Score: 93.13 %
3-Year Approval **January 1, 2013 to December 31, 2015**

Target Population

Coventry Health Care's (Coventry) Special Needs Plan (SNP) focuses on the dual eligible population and identifies members who are at risk for chronic health issues and socio-economic challenges. The plan operates in Christian and Greene Counties in Missouri where 12.2-14 percent of the target population are aged 65 or older, 2.7-3 percent are Hispanic, 3 percent are African American, 51.4 percent are female and 29 percent are obese. Among those members, there is a high occurrence of hypertension (15.7-19.1 percent) and diabetes (8 percent) with cancer also prevalent. Annually, the plan completes a robust analysis of its Dual-Eligible SNP population. This analysis includes enrollee characteristics relevant to the health risks/prevalence, utilization of services, and demographics including age, sex, race, ethnicity, language and disability or functional status, where available.

Provider Network

All major specialties and services are represented in Coventry's panel of participating providers such as hospitals and medical centers, laboratories, dialysis, long term care and skilled nursing facilities, rehabilitative facilities, and medical specialists such as but not limited to cardiologist, nephrologist, pulmonologist, primary care and behavioral health providers, home health service providers, dentists/oral health specialists, nurse practitioners and other ancillary providers.

Care Management and Coordination

Coventry performs a comprehensive initial health assessment (HRA) within 90 days of enrollment and an annual reassessment of the individual's medical, physical, cognitive, psychosocial and functional needs, and medical and mental health history. The assessment may be conducted via face-to-face interview, telephonically, or paper based. As different sections of the tool are completed, it collects but is not limited to the following: demographics, caregiver information, advanced directives, health conditions, nutrition, medications, clinical history, physical health, pain, and basic and instrumental activities of daily living.

The ICT uses the HRA findings, medical history and current clinical diagnostics and assessments to stratify case severity, develop and implement individualized care plans (ICP) with the member/caregiver. They will also identify standard and add-on benefits and services required by frail/disabled members and those near the end of life. With any condition change, the Interdisciplinary Care Team (ICT) will review and revise as appropriate the ICP with the member/caregiver. Reassessments are conducted with any health status changes (either clinical

or self-reported) and annually on or before the anniversary date of the last completed assessment to compare changes in health status and results are used to update the ICP.

In addition to the results of the HRA, specific services and benefits, outcome measures, preferences for care, add on benefits and services for vulnerable beneficiaries such as disabled or those near the end of life, the elements of the ICP include goals and interventions specific to each member in order to measure outcomes to determine if needs are met. It also addresses any barriers to achieving those goals and include benefits identified in the initial and subsequent risk assessment. The nurse case manager assesses the completed HRA and works with the ICT to develop the care plan.

Coventry assigns an ICT to each member; the composition is determined by member needs. The team consists minimally of a physician, usually the PCP, a social services specialist, pharmacist, nurse case/disease manager (CM) and behavioral health specialist to assure that the medical, functional, cognitive, and psychosocial needs are met. The nurse case manager coordinates the meetings. The ICP is updated by the ICT whenever the member's health status changes and like the HRA, on an annual basis. Members and their physicians are notified of any such changes.

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://chcmissouri.coventryhealthcare.com/