H4199 Florida Healthcare Plus Inc.
Chronic Condition (Cardiovascular Disorders, Chronic Heart Failure, and/or Diabetes) Special Needs Plan

Model of Care Score: 88.33%
1-Year Approval[1] **January 1, 2015 to December 31, 2015**

Target Population

The target population for Florida Healthcare Plus (FHCP) Chronic Condition Special Needs Plan are those eligible for Medicare benefits and services that are living with a chronic conditions such as diabetes, Chronic Heart Failure (CHF) and cardiac conditions. Members must reside in FHCP's South and Central Florida service area and have Medicare part A, part B and part D. FHCP offers a full range of coordinated medical, behavioral health and community based services including acute and chronic care, preventive care, rehabilitation and supportive long-term and home care. This population consists of the frail elderly with little or no support systems, non-English speaking members and those who express a need for assistance. Fifty five percent of members are male. Members are likely to have multiple co-morbidities and seek care from different specialists which can make care coordination more difficult for providers.

Provider Network

FHCP has 1,335 primary care physicians (PCP) and its specialty network includes mental health providers. Network specialists support primary care and case management resources for complex medical and social issues. The specific types of specialists and providers available to members include but are not limited to endocrinologists, cardiologists, nephrologists, dialysis centers, mental health centers, psychiatrists, psychologists, social workers and oncologists. FHCP also contracts with acute care hospitals, some with psychiatric units as well as psychiatric hospitals.

Care Management and Coordination

FHCP's initial health risk assessment (HRA) takes place within 90 days of enrollment and evaluates members' medical, psychosocial, behavioral, cognitive and functional needs and risks. An annual HRA is completed by all members for reassessment purposes. The initial HRA risk stratifies members and allows FHCP to track and analyze trends over time. When answers to the initial HRA identify a potential need or concern, the assigned care manager (CM) will follow up to obtain details on the member's needs or problems. The member's responses to the HRA are

[1] Per CMS, all plans that undergo the Cure process are limited to a one year approval, regardless of the final score.

recorded electronically. The HRA and stratification results are available to the interdisciplinary care team (ICT) members for review.

All members are assigned a CM upon enrollment, who is responsible for reviewing HRA results, subsequent comprehensive HRAs and additional evaluation of the information provided by the member. The CM also reviews available data and information gathered from the member's PCP/Specialist. All of this information is used to develop the ICP, identify and prioritize the most vulnerable members and to ensure immediate coordination of care and support. All providers caring for a member, the member and the ICT are notified of the HRA information and stratification via the ICP. CMs are registered nurses (RN), Master's level social workers or licensed clinical social workers. The CM will function as the care coordinator across all settings and providers.

The key components of the ICP include but are not limited to: PCP and other provider information; medication history; preventive measures and compliance; measurable goals to address and meet member's needs; potential barriers for meeting goals; outcome measures for each goal; transition of care needs; planned and unplanned continuity of care; documented referral to specific disease management program(s) and on-going follow-up and ICT communications/interventions and tracking of progress against ICP. Members are stratified into the low, moderate or high risk level. This is based on the HRA responses, and the CM's review of utilization, pharmacy, social services, authorization and claims information as well as information from the PCP or specialists in the member's records to manually upgrade risk if needed.

An individualized ICT is developed for each member. The ICT is composed of several key clinical disciplines, including the member and/or caregiver/designee, medical director, the CM, clinical pharmacist, PCP, specialty care providers and the delegated behavioral health provider. Additional members include nurse/diabetic educators, plan social worker and a disease management specialist. The CM reviews the care plan with the ICT to ensure their understanding of the goals established for the member and for the ICT's recommendations. The frequency of members' ICT meetings is determined by the individual level of risk found on the initial and yearly HRA as well as by any episodes of care and the member's medical, behavioral, social or preventive health needs.

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: https://floridahealthcareplus.com/