HealthSun Health Plan, H5431

Chronic or Disabling Condition (Diabetes Mellitus) Special Needs Plan

Model of Care Score: 90.63%
3-Year Approval **January 1, 2013 – December 31, 2015**

Target Population

HealthSun's C-SNP operates as a mixed model HMO with approximately 80% of members in staff model clinics and the remaining 20% of the membership in contracted independent physician associations (IPAs). The plan's service area consists of Miami-Dade and Broward Counties, Florida, which has a combined population of 4,244,501. Statistics demonstrate that approximately 8.7% of the adults in these counties have been diagnosed with diabetes. A closer evaluation of diabetes at the plan level shows that these individuals are substantially less healthy than individuals who do not have diabetes. The plan's membership consists of nearly 11,000 individuals of which 90% are over 65 years of age. Currently the SNP's membership is 87% Hispanic and 13% non-Hispanic. Nearly 9% or 975 individuals have a current diagnosis of diabetes.

Provider Network

HealthSun maintains a network of practitioners and providers that includes medical, behavioral health, specialty, home/community care and acute hospitals. It also consists of over 240 credentialed primary care practitioners (PCPs), over 570 specialists and 26 allied health professionals (e.g., physician assistants and nurse practitioners). HealthSun contracts with providers to care for the members' preventive/acute care needs and to provide care for those with multiple chronic conditions. Other ancillary services including, home health agencies, extended care, rehabilitation, DME, physical therapy and exercise are part of the established network of providers available to SNP members. HealthSun also looks to the availability and types of community agencies that may be of assistance to the member, such as Meals on Wheels, religious charities and senior centers throughout the service area.

HealthSun performs a review and analysis of access and availability of its larger network at least annually, but reviews the SNP network of practitioners and providers by counties within its service region at least two times annually to ensure that access and availability are sufficient.

Care Management and Coordination

The care management process begins with the completion of the health risk assessment (HRA). The HRA evaluates members' medical, behavioral, psychosocial, cognitive and functional needs. It also captures information that assists with the stratification of member health risks and supports the creation of an individualized plan of care (POC). HRAs are distributed by mail to members. The plan encourages members to be involved in their own care planning process

through the HRA. It sends the member any updates to the care plan within 14 business days of the review. HealthSun also encourages members to provide feedback once updates are made.

The provision of care management services to SNP members centers on an interdisciplinary team approach. The POC is developed with the input of an entire interdisciplinary care team (ICT). The ICT consists of the member, PCP and specialists (including behavioral health as appropriate), a case manager, a pharmacist, a consulting dietician, and the member's family or caregiver. Other participants may include allied health providers (e.g., nutritionist, exercise physiologist, certified diabetes educator) who become involved when the need for such disciplines is identified.

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 member needs.

For more information about this health plan refer to the Special Needs Plan's website at: www.healthsun.com