H5594 Optimum Healthcare, Inc.
Dual Eligible (Dual Eligible Subset – Medicare Zero Cost-sharing) Special Needs Plan

Model of Care Score: 100.00%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Optimum Healthcare, Inc.'s (Optimum) Dual-SNP (D-SNP) targets Medicare members who also have Medicaid eligibility status as determined by Florida. Its targeted members tend to be economically disadvantaged, with 58 percent living below the poverty level and 94 percent living below 200 percent of the poverty line. The population tends to have higher rates of diabetes, pulmonary disease, stroke and Alzheimer's disease compared to the non-dual eligible population. Many members have extensive health care needs, stemming from multiple illnesses and disabilities.

Women comprise 60 percent of the D-SNP's population and men 40 percent; the majority of members (56 percent) are between the ages of 55-74. Members generally experience comorbidities, most commonly: chronic obstructive pulmonary disease (10.3 percent), vascular disease (7.5 percent), renal failure (7.0 percent), polyneuropathy (6.9 percent) and psychiatric conditions, such as major depressive, bipolar and paranoid disorders (6.7 percent).

Provider Network

Optimum has a network of providers and board- certified specialists with clinical expertise that include: internists, pulmonologists, cardiologists, general and cardiovascular surgeons, endocrinologists, optometrists, ophthalmologists, podiatrists, neurologists, nephrologists, rehabilitation services, home health services, durable medical equipment services, social workers, mental health specialists, and pharmacists and/or clinical pharmacists. In addition to these specialists, Optimum has a vast primary care network including providers specializing in internal medicine, geriatric medicine and family practice.

Its network also consists of: acute care hospitals, tertiary medical centers, laboratory providers, skilled nursing facilities, pharmacies, free-standing radiology facilities, wound care centers and outpatient cardiac, pulmonary, respiratory therapy and rehabilitation centers.

Care Management and Coordination

Within 90 days of enrollment and annually thereafter, each member completes an initial comprehensive health risk assessment (HRA). The responses reflect the member's perception of his or her medical, psychosocial, cognitive and functional status to identify potential care gaps. As

applicable, Optimum conducts a separate disease-specific assessment health assessment for members indicating a chronic disease.

Based on a review and analysis of the member's responses and depending on his or her risk stratification level (Tier 1, 2 or 3), either the nurse/social worker's (NCM/SW) or primary care physician (PCP) develops the individualized care plan (ICP). The essential elements of the ICP are problems, goals and interventions. In the ICP, the interdisciplinary care team (ICT) prioritizes goals for a member's health status, establishes timeframes for reevaluation, identifies resources to benefit the member (recommendations to appropriate level of care) and outlines a plan for continuity of care (including transitions).

As care management conversations occur between nurse case managers, PCPs, members, and other key member ICT participants, case notes are documented in the health plan's case management system and updates are made to the ICP and communicated to the care team. The PCP always gets a faxed copy of the updated care plan, which supplements verbal notification through telephone contact. The PCP as the "medical home" is on point to disseminate the information to other key stakeholders including specialists, facilities etc. It is also the PCP's responsibility to ensure that the revised ICP is acted upon and implemented to assure quality outcomes. Member cases are also presented and discussed at the formal, quarterly ICT meeting attended by administrative and clinical personnel, pharmacy and physician committee members.

The composition of the ICT is based on the problems, interventions and goals established during the care planning process. Core members of the ICT include: the PCP, the NCM/SW, specialists and other care professionals and the member/caregiver. Depending on the member's condition and unique needs, additional expertise may be added to the ICT.

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://www.youroptimumhealthcare.com/medicare/special_needs_plan_info_members