Physicians United Plan, INC., H5696
Dual Eligible (Dual Eligible Subset - Medicare Zero Cost-sharing)
Special Needs Plan

Model of Care Score: 95.63%
3-Year Approval **January 1, 2014- December 31, 2016**

Target Population

This plan is available to those dually eligible for Medicare and Medicaid in 17 counties in central and eastern Florida. Enrollment eligibility includes "All Duals" including Qualified Medicare Beneficiary without other Medicaid (QMP only); QMP Plus; Specified Low-Income Medicare Beneficiary without other Medicaid (SLMB only); SLMB Plus; Qualifying Individual (QI); other full benefit dual eligible (FBDE); and Qualified Disabled and Working Individual (QDWI). These members are typically older, with multiple co-morbid conditions. Many require assistance in identifying and obtaining basic medical, social and educational services and require advocacy and guidance in obtaining services and navigating the benefits to which they are entitled.

Provider Network

The plan maintains a provider network with the specialized expertise to care for a special needs population, including facilitating and coordinating enhanced benefits for dual eligible members. This includes primary care providers, specialists such as cardiology, nephrology, geriatrics, oncology, behavioral and mental health specialists, physical therapists, podiatrists and facilities such as acute care hospitals, ambulatory surgery centers, diagnostic imaging centers, dialysis centers, skilled nursing facilities and laboratory facilities as well as home health services The plan uses patient-centered medical homes (PCMH) to coordinate care and communication among the interdisciplinary care team (ICT). The member's primary care provider (PCP), who serves as the member's medical home, is responsible for a majority of member care coordination and determining medical services appropriate for each member, including specialist referral for treatment for a complex condition, such as diabetes.

Medical specialists, the plan's medical director and care coordination team are resources to the PCP. The care coordination team works collaboratively with the PCP to examine the member's benefits and assist them in obtaining the benefits to which they are entitled. Nurse care coordinators serve as liaisons between the member, PCP and other providers involved in the member's care.

Care Coordination and Management

The plan uses a health risk assessment (HRA) that addresses the medical, mental health, psychosocial, cognitive status and functional needs of the member. The plan uses the assessment to determine which benefits a member may need. Individualized care plans (ICP) are created by nurse care coordinators using the HRA results and input from other plan personnel, the member's PCP and the member directly, if they are willing and able to do so. Members are grouped into one of four categories that correspond to an acuity level. Members in the higher categories may receive regular calls or visits from nurse care coordinators. The essential elements of the ICP include: individualized needs for medical, specialty and social benefits and services, short and long term goals and objectives, potential barriers and measurable outcomes. Member, caregiver/responsible parties, preferences, end of life needs and other unique needs may also be incorporated in the member's ICP. This assessment is conducted by phone within 90 days of enrollment and then annually thereafter unless there is a change in health status that requires reassessment.

The ICT is a key component in the care coordination of members. The team is designed to address the various aspects of members' medical, behavioral health and social needs. The team is comprised of a core membership of the member's PCP, the plan's medical director, nurse care coordinators, and if possible, the member and/or his/her designated caregiver. Other ICT members participate on an ad-hoc basis as determined by the member's specific medical needs such as behavioral health specialists, pharmacists, home health providers or other medical specialists. Members may participate in ICT meetings via phone or in person.

The PCP also evaluates the member's responses to interventions, effectiveness of the ICP and updates the ICP accordingly. Nurse care coordinators identify any planned transitions in care such as an upcoming surgery or discharge from a hospital and communicate those changes in the member's individualized care plan (ICP) and to the PCP and member.

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://www.uaskpup.com.