Coventry Summit Health Plan, H-5850
Dual (All Duals) Special Needs Plan

Model of Care Score: 98.75%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

Coventry Summit provides comprehensive care management to members who qualify for its dual eligible SNP in Florida. Seventy-four (74) percent of the members are 65 years of age or older and 57 percent of the members are female. In this target population, the top chronic conditions by prevalence are diabetes, joint degeneration/inflammation, neurology and cardiology and top conditions ranked by cost are diabetes, renal failure, neurology and heart failure/cardiomyopathy.

Provider Network

Coventry Summit contracts with a variety of providers to meet the needs of the SNP population. All major specialties and services are represented in the SNP's panel of participating providers, such as acute care facilities equipped to manage the dual eligible members who have multiple, severe, chronic conditions, long term care needs or members who may have at least one cognitive or mental impairment. The network is comprised of hospitals and medical centers, psychiatric facilities, laboratories, long term care and skilled nursing facilities, pharmacies, radiological and imaging facilities, rehabilitative facilities, primary care providers (PCP), home health service providers, behavioral health specialist, dentists/oral health specialists, dialysis facilities, nursing professionals and allied health professionals. Additional services include specialized clinical expertise and medical specialists (such as cardiologists, nephrologists and geriatric specialists), disease management, wound care, pharmacotherapy consultation and management, home safety assessments, fall prevention, wellness promotion, long term care, palliative care and end of life care. The primary care provider (PCP) is the gatekeeper and is responsible for identifying the needs of the member.

Care Management and Coordination

The health risk assessment (HRA) tool was designed to identify key SNP member care needs, including medical, psychosocial, functional and cognitive needs. It is developed using the interdisciplinary care team (ICT) oversight with input from the provider and member community and integrates the specialized needs of each member. The assessment is conducted within 90 days of member enrollment and annually via face-to-face interview, by phone or paper-based. Additionally, a reassessment will be conducted if any flagged health changes are identified by claims data mining, clinical provider or member self-reported.

The HRA tool is pre-populated with provider network claims and encounter information including medical, pharmacy, laboratory and facility data. The HRA tool allows for validation of pre-populated data while collecting member reported information. As different sections of the HRA tool are completed, the tool uniquely stratifies the member using the combined data elements. In addition, the HRA uses the member's responses in conjunction with preprogrammed logic to trigger the need for supplemental assessments which are triggered based on a member's condition.

Coventry Summit developed a comprehensive individualized care plan (ICP) that addresses the member's particular needs. The member's care plan includes an itemized list of issues, interventions and goals, which are separated into distinctive categories: clinical, functional, preventive measures, psychosocial and compliance. Each member's care plan identifies goals that reflect their unique needs, are realistic and measurable, include a time frame for achievement as appropriate, identifies services and care to meet member's care goals, and connects the member/caregiver with add-on benefits and services. The nurse case manager, in conjunction with the member, initiates the care plan, assesses the completed HRA tool and works with the interdisciplinary care team (ICT) to develop the ICP. Frequency of care plan review is determined by the member's needs, but at a minimum twice yearly and also when triggered by any significant changes in the member's health status.

The composition of the ICT is determined by the needs of the member. The team consists minimally of the member and/or caregiver, a physician (usually the PCP), social services specialist, pharmacist, nurse case/disease manager and behavioral health services specialist to assure that the medical, functional, cognitive and psychosocial needs of the member are considered in the care planning. Other disciplines will be added as appropriate to meet the member's needs. The ICT meets on a biweekly basis to discuss the members.

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://coventry-medicare.coventryhealthcare.com/coventry-health-care-of-florida/index.htm