H4199 Florida Healthcare Plus Inc.
Dual Eligible (Dual Eligible Subset) 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) Dual Eligible Subset Special Needs Plan are those dually eligible for Medicare and Medicaid benefits and services who reside in FHCP's service areas which include South and Central Florida. FHCP's Miami-Dade County membership and the Tampa Bay area membership have the largest number of Hispanics and Spanish speakers of the total dual population. About 40 percent of members are Black, 31 percent are White and 24 percent are Hispanic. Forty-four percent of members are between the ages of 64-74; 25 percent are between 45-64 years of age and 18 percent are between 75-84 years old. More than half of members are female (55 percent). Members tend to be frail and elderly with little or no support systems, non-English speaking and express a need for assistance. FHCP takes into consideration that members in less populated areas may have more challenges accessing care compared those in large metropolitan areas. FHCP assists members to meet their needs by assigning a specialized care manager by region who provides clinical and social resources management knowledge to facilitate care.

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. FCHP 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 FCHP to track and analyze trends over time. When answers to the initial HRA identify a need or concern, the assigned care manager (CM) will follow up to obtain

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

details on the member's needs or problems. The member's responses to the HRA are recorded electronically. The HRA and stratification results are available to the interdisciplinary care team (ICT) for review.

All members are assigned a CM who is responsible for reviewing HRA results, subsequent HRAs and additional evaluation of the information provided by the member. The CM also reviews available data and information 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.

The key components of the ICP include but are not limited to: PCP and other provider information; medication history; preventative 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, and 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 an understanding of the member's goals and for the ICT's recommendations. The frequency of members' ICT meetings is determined by the member's risk level 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/