Care Improvement Plus of Texas, H0084
Chronic or Disabling Conditions
(Cardiovascular Disorders, Chronic Heart Failure, Diabetes)
Special Needs Plan

Model of Care Score: 78.75%
2-Year Approval **January 1, 2014 – December 31, 2015**

Target Population

Care Improvement Plus (CIP) is a Chronic Condition SNP that operates in Texas and specializes in cardiovascular disorders, chronic heart failure, and diabetes. Almost 50% of members are permanently disabled (e.g., blind, amputees, kidney failure). The average age of the non-disabled membership for this C-SNP is 76 years old with 68% of the members not having completed high school. The majority of the population (77%) live in rural areas. Almost 45% of the enrollees are African American. The majority of the members take 11 to 14 unique prescriptions or forms of medication. The prevalence rate of diseases for which CIP specializes in is 21% for diabetes and 10% for heart failure in Texas.

Provider Network

CIP maintains a network of inpatient and outpatient providers for the special needs population that is designed to provide access to all major services for members. The provider directory delineates those who accept Medicare and Medicaid. Additionally, CIP uses an open access model, which means that members may self-refer to contracted providers; they may also seek care from any Medicare/Medicaid participating provider who is willing to bill CIP.

CIP offers access to a mental health network, in partnership with Optum Behavioral Health that includes counseling, inpatient and outpatient services. The CIP behavioral and mental health network includes: psychiatrists, clinical psychologists, clinical social workers, addiction specialists and mental health field workers who work with members in the home setting. In addition to behavioral health, CIP also offers access to licensed facilities (hospitals, skilled nursing facilities, etc.), primary care providers (PCP), case management and specialists.

Care Management and Coordination

CIP utilizes disease specific, functional and psychosocial individualized plans of care (POC) whose structure is based on evidenced based guidelines. The nurse care manager initiates the creation of the POC following a review of the health risk assessment (HRA), disease specific

assessments, administrative claims, pharmacy data and other data assessments. All available data as well as the member's verbalized health needs and goals drive the initial population of the POC. The POC is updated as additional data is received over time. The POC must be reviewed and can be revised at any time by interdisciplinary care team (ICT) members, preferably with input from the member. As each member of the ICT is introduced and initiates care for the member, the nurse care manager enters relevant information (e.g., member's health status, visit summary) into the POC.

The core members of the ICT include the member, the member's personal physician, the nurse care manager, the clinical pharmacist and other practitioners. Additional members such as a caregiver, social worker, behavioral health professional, specialty physicians, ancillary health and community based professionals may be added to the ICT according to the member's needs as reflected in the POC. Potential additional members of the ICT include; nutritionists, home health professionals, rehabilitation specialists, physician specialists, community health care workers, pain management specialists, palliative care and hospice professionals, transitions care managers, respiratory therapists and utilization management (UM) nurse.

CIP selects ICT members based on the expected needs of its dual eligible population. The member is assigned to a specialized ICT according to identified need as determined through initial and ongoing assessments. Core members of the ICT remain consistent while additional members may participate for limited time-frames to address specific identified 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 member needs.

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