Cigna Healthcare of Arizona, INC. H0354
Chronic (Chronic Heart Failure, and Diabetes) Special Needs Plan

Model of Care Score: 91.88%
3-Year Approval **January 1, 2013 – December 31, 2015**

Target Population

Cigna HealthCare of Arizona's (CHC-AZ) target population includes members with a combination of chronic conditions such as diabetes mellitus (DM), congestive heart failure (CHF), and cardiovascular disease (CVD) in Maricopa County, Arizona, and the city of Apache Junction. Prevalence and incidence of CHF increase with age and diabetes-related comorbidities, in particular, ischemic heart disease and renal insufficiency. The detrimental effect of CHF on individuals with DM is highlighted by the dramatically higher mortality rates among individuals with CHF compared with those who remain CHF free. CHF remains an important clinical finding in the Medicare population, affecting more than one in 10 members.

Provider Network

In addition to providing services through CHC-AZ owned and operated health care centers, pharmacies, urgent care centers and outpatient surgical centers, CHC-AZ provider network includes home health, radiology (cardiovascular studies), laboratories, behavioral health and over 2500 private practice specialty physicians; 50 outpatient surgery centers, urgent care and dialysis centers; 60 skilled nursing facilities; and 25 acute care hospitals to provide wrap-around specialty referral, ancillary and facility services not available within Cigna Medical Group (CMG). Of particular note for the management of this SNP population, CHC-AZ contracts with 10 interventional cardiologists, 10 cardiovascular surgeons, 401 cardiologists, 8 electrophysiologists, and 230 endocrinologists all across Maricopa County. Cardiac rehab services are provided at 26 facilities. Additionally, CMG employs various specialists that co-manage chronic conditions with the PCP.

Care Management and Coordination

The health risk assessment (HRA) is the evidence-based interview tool that establishes medical, psychosocial, functional, cognitive, behavioral, mental health and preventive care history as well as current needs on an initial and ongoing basis as reported by the beneficiary. The HRA contains questions that establish a deeper understanding of members' psychosocial, functional and medical needs, including depression, pain, and anxiety screens that identify members who may need referral to behavioral health services, and functional and social needs inventories that identify need for community support such as home health, or case management services. The HRA allows identification of immediately required services, is scored for risk stratification, and, along with select administrative data, is the first step in production of the individual care plan (ICP). The HRA also targets gaps in preventive care such as routine screenings and immunizations, and contains assessment questions and outlines clinical management protocols that are based on the most current evidence-based guidelines, which are updated yearly to ensure that guidelines are clinically relevant and timely.

The interdisciplinary care team (ICT) is structured to provide the most efficient and comprehensive management of the HRA and ICP processes, and the composition of the team is chosen with those goals in mind. Critical participants of the core team, in addition to the member, include: the PCP, care coordinator, behavioral health specialist and a social worker.

The individuals involved in the initial development of the ICP will primarily include those individuals associated with the HRA and ICT. Thereafter, the ICP will be reviewed by the PCP with the member as necessary in the normal conduct of medical management. Aspects of the ICP that need internal and external services, such as contracted specialty needs, are arranged by the PCP or the assigned CHIP nurse associated with the HRA process and tracked by the ICT and administrative team. This initial ICP is reviewed by the PCP and the ICT at its monthly meeting and upon each subsequent interaction with the SNP member or, at minimum annually, to ensure compliance to care plan goals.

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:
www.cigna.com