H0439 Cigna-HealthSpring
Dual Eligible (All Dual) Special Needs Plan

Model of Care Score: 100.00%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Cigna-HealthSpring Dual Eligible Special Needs Plan (D-SNP) targets individuals eligible for Medicare and full Medicaid coverage who reside in one of Cigna-HealthSpring's service areas within Georgia.

Membership across all of Cigna-HealthSpring's D-SNPs, to which Cigna-HealthSpring belongs, is predominantly female (57 percent) with 36 percent of members under the age of 65. The average age of dual members is 66 years old, and approximately 7 percent are over the age of 85. Approximately 65 percent of members live in urban areas and 22 percent live in rural areas. The top five health conditions experienced by its D-SNP population are diabetes (42 percent), ischemic heart disease (30 percent), major depression (20 percent), chronic obstructive pulmonary disease (14 percent) and congestive heart failure (13 percent). The primary cognitive diagnoses among members are intellectual disabilities (2.24 percent) and various types of dementia (6.19 percent). Over 40 percent of their members are affected by various mental health issues. The ethnic diversity among Cigna-HealthSpring's members is reflected as: White (48 percent), Black/African American (46 percent), Asian (3 percent) and Hispanic or Latino (1 percent).

Provider Network

Cigna-HealthSpring offers its members access to a network of contracted facilities, primary and specialty care physicians, behavioral/mental health specialists and alcohol/substance abuse specialists, as well as a complete ancillary care network. According to the needs of its members, Cigna-HealthSpring concentrates its efforts on meeting or exceeding the minimum network adequacy guidelines for the following specialties: cardiology, cardiac surgery, endocrinology, psychiatry and pulmonology. Cigna-HealthSpring's network includes facilities pertinent to the needs of D-SNP members such as inpatient, outpatient, rehabilitative, psychiatric, laboratory, radiology/imaging and Cigna-HealthSpring LivingWell Centers. Their network also includes allied health professionals such as physical therapists, occupational specialists, speech pathologists and radiology specialists.

Before receiving specialized services, members consult with their primary care physician (PCP) and obtain a referral. Case managers (CM) may work closely with the most vulnerable members to discuss needed specialist services and follow-up to ensure those services have been received in

a timely manner. Finally, clinical staff within the utilization management department assists providers in facilitating members' care transitions and specialist needs.

Care Coordination and Management

Within 90 days of enrollment and annually thereafter, Cigna-HealthSpring staff uses a health risk assessment tool (HRAT) to assess the medical, psychosocial, cognitive and functional needs of each member, including medical and mental health history and environmental influences. The member completes the HRAT by mail, telephone, or in person and Cigna-HealthSpring documents their responses in the integrated care management application where they are accessed by the interdisciplinary care team (ICT). In addition to the HRA tool itself, subsequent more comprehensive case management assessments such as the case management general assessment, behavioral health case management assessment or 360 exam may be conducted as determined by member needs.

Individualized care plan (ICP) development requires information collected during the HRA, findings from comprehensive follow up assessments or care visits to determine the member's needs and the member's risk level. The ICP includes the member's self-management goals, barriers, health care preferences as well as specifically tailored services and interventions. The CM reviews the ICP during each member contact and/or when there are changes in the member's health status or unplanned acute admissions and updates it accordingly. The ICP can also be reviewed and potentially revised during ad hoc or pre-scheduled ICT meetings.

The core members of the ICT include: the member, their caregiver or family, and the PCP. Based on the member's specific needs, a medical director, social worker, case manager, pharmacist and other providers or specialists may be added to the ICT. As a group, they are responsible for collaborating to resolve the member's health issues, develop and maintain their ICPs and coordinating their care.

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.cignahealthspring.com