HealthSpring Life & Health Insurance Co. Inc., H1415
Dual Eligible (All Dual) Special Needs Plan

Model of Care Score: 98.75%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

HealthSpring's target population is unique as most members are younger than the Medicare age of 65 and members who qualify for Medicare Part A and B and Medical Assistance from a State Plan under Title XIX (Medicaid). This includes members who are eligible for Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individual (QI-1), Supplemental Security Income (SSI-Medicaid) and Qualified Disabled and Working Individuals (QDWI). The dual-eligible population are aged, blind, disabled, not financially eligible for medical assistance, and have limited income and assets. The most prevalent conditions among this population are cardiac conditions, diabetes, mental health/substance abuse issues, and congestive heart failure.

Provider Network

HealthSpring offers members access to a network of contracted facilities, primary care and specialty care physicians, behavioral health, mental health, and alcohol and substance abuse specialists, as well a complete ancillary care network. Members are encouraged to visit their primary care physician (PCP) first for any non-emergent care needs. In order to see specialists or other network providers, a PCP referral is required. HealthSpring also maintains a unique position within some markets to help direct members to the care and services they need through advanced care clinics, living well clinics staffed with physicians and other clinical staff members, who are able to provide a large array of services for walk-in and scheduled appointment needs. The case managers act as coaches for the member to facilitate care.

Care Management and Coordination

The health risk assessment (HRA) is a comprehensive assessment of the medical, psychosocial, cognitive, and functional needs of the member and includes medical and mental health history as well as environmental influences. The plan conducts the initial assessment within 90 days of enrollment and annually thereafter. The HRA tool may be completed by mail, telephone, or in person by a healthcare professional. In addition to the HRA, HealthSpring utilizes an SF-8 survey which assesses the need for care management or home and community-based services.

Once the member's HRA responses are inputted into a clinical management system, referrals to either behavioral health or case management is provided.

The plan maintains an individualized care plan (ICP) for each member that is updated throughout their membership. A case manager works with the member to create the ICP. The care plan is developed with the HRA responses in mind, and includes identification of barriers such as transportation needs, health coaching, end of life needs such as advance directives or living wills, community referrals and other needed resources. The ICP is a living document and is updated and refined with each member contact. Case managers personalize the plan by adding or modifying care goals and protocols and discuss changes directly with the member, including any health status changes.

HealthSpring's interdisciplinary care team (ICT) was developed to ensure efficient coordination of care, especially through the members' care transitions, and improve health outcomes. The core ICT consists of a medical director, case manager, licensed social worker, behavioral health case manager, inpatient nurse reviewer, precertification nurse and managerial staff. Other staff that may be included are office based HealthSpring practice coordinators, behavioral health and substance abuse specialists, clinical pharmacists, member services representatives, family members and caregivers. The case manager acts on behalf of the member as his/her representative to address concerns or issues brought to the attention of the ICT for resolution; however, the member can be present or directly participate during the face-to-face meetings. The ICT functions at two levels: 1. ICT members participate in numerous, regularly scheduled care meetings in order to execute program goals and 2. The ICT meets quarterly and is charged with the strategic development and execution of care management initiatives to improve the health of 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://starplus.cignahealthspring.com/