Bravo Health Inc., H2108, H3949
Institutional (Institutional Facility) Special Needs Plan

Model of Care Score: 95.63%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

The target population for this special needs plan (SNP) is the institutionalized Medicare members who reside, or are expected to reside, in a long term care facility for 90 days or longer. Institutionalized members are disproportionately cognitively or mentally impaired, in fair or poor health, female, over age of 85 and low income. These members account for a disproportionate share of Medicare spending and have high rates of hospital visits, emergency room visits and skilled nursing facility admissions. With the institutionalized member's higher risk of poor health due to frailty and/or multiple chronic illnesses, the likelihood of disruptive and clinically unnecessary transitions of care increases.

Provider Network

Cigna-HealthSpring offers a provider network with clinical expertise specially designed to meet the needs of members in long term care (LTC) facilities, including primary care providers and specialists that evaluate, recommend or complete treatments to optimize health status, including treating the member in place. Members are assigned a nurse practitioner (NP) who has responsibility for the continuous, coordinated and comprehensive care of the member, leads the interdisciplinary care team (ICT) and is available 24 hours per day 7 days per week.

Cigna-HealthSpring contracts with LTC facilities to support the execution of this SNP. The SNP also contracts with medical and behavioral health specialists as well as acute and outpatient facilities to assure access to the appropriate level of care to the members. Frequently utilized providers include cardiology, nephrology, gastroenterology, neurology, pulmonology, dermatology, ophthalmology, psychiatrists/psychiatric NPs, acute care centers, wound care centers, dialysis centers and ambulatory surgery centers. Cigna-HealthSpring also directs members to Cigna-HealthSpring Living Well Clinics staffed with physicians and other clinical staff members, who are able to provide an array of services for both walk-in and scheduled appointment needs.

Care Coordination

Cigna-HealthSpring utilizes a comprehensive history and physical examination, and the NP risk assessment and triage tool to assess the health risk of the members. Upon enrollment (within the first 30 days) and at least annually thereafter, NP's complete the assessments in-person as part of

the initial face-to-face interaction. The results of these assessments are used to create a detailed problem list and an individual treatment plan for each member, including specific monitoring activities and stratifying members into three levels of intervention intensities. These intervention intensities determine the frequency of episodic visits and are significantly more intense than the care typically provided.

The NP develops the individualized care plan (ICP) and reviews the ICP with the ICT. The NP also consults with skilled nursing facility (SNF) staff and communicates the ICP to the member and/or caregiver to confirm understanding. The ICP addresses all aspects of the member's physical and mental health, present acuity, functional assessment, cognitive exam, geriatric depression scale, pain assessment, linguistic and benefit needs. It also establishes short and long-term goals (outcome measures) and identifies barriers to care for mitigation, where possible. In addition, the ICP incorporates the member's preferences for care and advance directives, including end of life wishes. It is developed within 30 days of enrollment and is reviewed and revised annually thereafter. However, the ICP is also revised when the member experiences a change of health status, a transition to or from an acute care facility, or a desire to modify their end of life wishes.

The ICT, at a minimum, consists of a NP, care coordination team, network (primary care physician) PCP and appropriate administrative support staff. In addition, the SNP engages the staff at the nursing facility, including nursing staff, restorative specialists, clinical pharmacist, therapists and licensed clinical social workers specializing in behavioral health and the coordination of social services. The ICT is supplemented on a case-by-case basis by network providers with skills matched to the unique needs of the member. This may include behavioral health and substance abuse specialist, clinical pharmacists, member service representatives and family members/caregivers. ICT members meet on a weekly basis via telephone or in-person to round on all members who have been transitioned to the acute setting.

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