

H2108 Cigna-HealthSpring Institutional (Facility) Special Needs Plan

Model of Care Score: 100.00%

3-Year Approval

January 1, 2015 – December 31, 2017

Target Population

Cigna-HealthSpring Institutional (Facility) Special Needs Plan (I-SNP) targets beneficiaries who reside, or are expected to reside, in a Cigna-HealthSpring-contracted, long-term skilled nursing facility (SNF) for 90 days or longer and do not have end-stage renal disease at the time of enrollment. The plan currently operates in Maryland and Pennsylvania and is proposing to expand to both Delaware and the District of Columbia. When compared to non-institutionalized Medicare members, institutionalized members are disproportionately cognitively or functionally impaired, in fair or poor health, female, over age 85, African American and low income.

All Cigna-HealthSpring I-SNP members have at least one chronic illness: vascular disease (60 percent), renal failure (40 percent), congestive heart failure (30 percent), chronic obstructive pulmonary disease (30 percent), diabetes with renal or peripheral circulatory manifestations (27 percent), a history of stroke (25 percent), specified heart arrhythmias (22 percent) and a diagnosis of seizure disorder (18 percent). The primary behavioral and cognitive conditions among members include intellectual disabilities and various types of dementia.

Provider Network

Cigna-HealthSpring contracts with medical and behavioral health specialists, as well as acute and outpatient facilities, to assure access to the appropriate level of care to this population. Frequently utilized providers include, but are not limited to: cardiology, nephrology, gastroenterology, neurology, pulmonology, dermatology, ophthalmology, psychiatrists and psychiatric nurse practitioners, acute care centers, wound care centers, dialysis centers and ambulatory surgery centers. Members can access needed services on either a walk-in or appointment basis at Cigna-HealthSpring Living Well Centers. Members can also access multiple specialty services - dental, vision, podiatry, audiology and psychological – inside their SNF through Cigna-HealthSpring's Care Clinics program. If a member requires treatment that cannot be provided in the SNF setting, then the plan's care coordination team offers appointment scheduling assistance and unlimited routine transportation. In addition to having access to an adequate network of professional, ancillary and facility providers, members are assigned a nurse practitioner (NP) who leads the interdisciplinary care team (ICT) and is available 24 hours per day, 7 days per week.

Care Management and Coordination

Within 30 days of enrollment, the NP conducts a comprehensive, face-to-face assessment that includes a history and physical examination and a risk assessment and triage tool (RATT). The risk score will drive the NP's visit schedule (e.g. daily, weekly, bi-weekly or monthly) with the member. Cigna-HealthSpring's assessment includes additional content such as: advanced directives care planning, reviews of high-risk members, screening tools for conditions such as cognitive impairment and depression and a functional status assessment.

The NP creates an individual care plan (ICP) that addresses the findings of the history and physical examination and the RATT. It also establishes both short and long-term goals and identifies barriers to care. In addition, the ICP incorporates the member's preferences for care and advance directives, including end-of-life wishes. The NP reviews the ICP with the member and/or caregiver and the primary care provider (PCP) and then updates it at least monthly during the member's comprehensive visit. 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.

Cigna-HealthSpring uses two complementary types of ICTs to support member care management. The first is the member-level ICT which is tailored to the needs of the individual member and the second is the plan-level ICT which is designed to meet the needs of high-risk members. The member-level ICT typically includes the member, member's caregiver, NP, PCP, any relevant specialists, and the facility staff. The plan-level ICT is comprised of plan staff with expertise best suited for addressing the care needs for the highest risk, most vulnerable members. Plan-level participants may include, but are not limited to: behavioral health case managers or providers, the medical director, social workers, case managers, pharmacists and behavioral health specialists. ICT members meet on a weekly basis via telephone or in-person to review all members who have been transitioned to an 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