H3949 Cigna-HealthSpring
Chronic or Disabling Condition (Diabetes Mellitus) Special Needs Plan

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

Target Population

Cigna-HealthSpring Chronic Diabetes Mellitus Special Needs Plan (C-SNP) serves individuals who are entitled to Medicare Parts A and B and eligible for Part D, have a physician confirmed diagnosis of diabetes mellitus and live in one of Cigna-HealthSpring's service areas within Pennsylvania.

Disease prevalence among Cigna-HealthSpring's C-SNP membership follows: diabetes (100 percent), ischemic heart disease (38 percent), major depression (12 percent), congestive heart failure (11 percent), chronic obstructive pulmonary disease (10 percent), stroke/transient ischemic attack (5 percent) and Alzheimer's disease (3 percent). The top five behavioral health admission diagnoses among their C-SNP members are: psychosis (26 percent), schizophrenia (24 percent), depressive disorder (18 percent), schizophrenia – paranoid type (12 percent), bipolar disorder (10 percent) and depressive disorder/major recurring severe psychotic behavior (10 percent).

The ethnic diversity among Cigna-HealthSpring's C-SNP members is: Black/African American (61 percent), White (35 percent), Asian (2 percent), Hispanic or Latino (0.77 percent) and American Indian or Alaska Native (.09 percent). Eighty-five percent of members prefer English and 4 percent prefer Spanish. The top three medical conditions among these members include: hypertension (75 percent), arthritis (54 percent) and diabetes (33 percent).

Provider Network

Cigna-HealthSpring offers members access to a network of contracted facilities, primary and specialty care physicians, behavioral/mental health and alcohol/substance abuse specialists as well as a complete ancillary care network. To best meet the care needs of their diabetic members, Cigna-HealthSpring's network includes podiatrists, orthopedic surgeons and vascular surgeons. Members can also access allied health professionals such as physical therapists, occupational specialists, speech pathologists and radiology specialists. In response to the challenges of overseeing members living in disparate environments (such as inner city or rural/remote locations) who may not have a consistent address, access to telephones or internet or reliable transportation, Cigna-HealthSpring operates community-based care coordination programs, physician-led chronic care management services and Cigna-HealthSpring LivingWell Centers to

ensure that their most vulnerable members have access to high quality complex case management and/or primary care services.

Cigna-HealthSpring requires that members receive a referral for specialist care from their primary care physician (PCP). Consequently, PCPs are responsible for being aware of the health status of all members, including understanding their risk status and service utilization.

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 then Cigna-HealthSpring documents their responses in the integrated care management application where they are accessed by 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 core interdisciplinary care team (ICT) members include: the medical director, the CM, the PCP, a social worker and the member and/or caregiver. The ICT is supplemented on a case-by-case basis by network providers with skills matched to the unique needs of the member such as an endocrinologist, behavioral health and substance abuse specialists, clinical pharmacists, a community liaison, a home health aide and member services representatives. ICT members participate in numerous, regularly scheduled care meetings and hold frequent ad hoc meetings to review pressing care-related issues.

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