HealthSpring of Tennessee, H4454, H4407, H5410, H0150
Dual-Eligible (Full Benefit) Special Needs Plan

Model of Care Score: 100%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

The plan targets those with Medicare and Medicaid. The target population tends to have more chronic conditions than the overall Medicare population, with cardiac conditions, diabetes, chronic obstructive pulmonary disease (COPD), mental health/substance abuse issues and congestive heart failure the most prevalent. Almost all members of the plan have more than one health condition, including mental health concerns, which affect more than 40% of members. Slightly more than one-third (36%) of members are younger than the usual Medicare age of 65 and two-thirds (65%) live in urban areas, while 22% live in areas classified as rural.

Provider Network

Cigna-HealthSpring offers members access to a network of contracted facilities, primary care and specialty care physicians, behavioral and mental health and alcohol and substance abuse specialists, as well as a complete ancillary care network. The network strives to provide greater access to providers treating the most common conditions within the plan, which include cardiac conditions, diabetes, mental health/substance abuse issues, and congestive heart failure. The network also includes facilities such as Cigna-HealthSpring LivingWell Centers, which offer vulnerable members access to complex case management and primary care services and a place for members to meet face-to-face with their interdisciplinary care teams (ICT). Members choose a primary care physician (PCP) and must seek a referral to specialists from the PCP.

The member's PCP is encouraged to conduct an annual in-depth assessment of members' overall health and services to use for care planning and maintaining members' individualized care plans (ICP). PCPs may participate in the plan's Partnership for Quality Program (P4Q) and receive bonus payments for demonstrating improvement in the quality of care delivered to members. The plan has identified indicators to determine quality improvement, based on evidence-based guidelines and existing quality and disease management initiatives in the following areas: preventive medicine, diabetes management, congestive heart failure, coronary artery disease and pharmacy.

Care Coordination and Management

New members must choose a primary care physician (PCP) who will provide routine care and coordinate other services including referrals to see a specialist. Members with more complex needs are placed into case management programs and assigned a specific case manager, who will act as a liaison between the member, the plan, and all providers involved in the member's care. Case managers are responsible for coordination of all benefits and services, initial and periodic assessments, development, maintenance and execution of the member's ICP and proactive management of all assigned members. The plan uses a health risk assessment (HRA) tool to assess medical, psychosocial, cognitive and functional needs of each member, including medical and mental health history and environmental influences. This information, along with claims, laboratory and pharmacy data is used to create a risk profile for each member. Services are tailored based on the risk score. The case manager will work with the member to set goals and identify appropriate interventions.

For members placed into case management, the case manager will use the information in the development of the ICP and selection of the ICT. For members not in case management, a care plan is generated based on the member's HRA responses or a team of clinical nurses and licensed social workers customize the care plan and contact the member for participation. Members are encouraged to participate in the development of the ICP, especially the goals.

The ICT functions at two levels, focusing on individual members as well as on the overall membership population. The ICT consists of the member, their caregiver or family, if applicable, the member's PCP, plus a core of plan employees such as a medical director, social worker, case manager, pharmacist and other providers or specialists based on the member's specific needs. It is responsible for collaborating to resolve members' health issues, develop and maintain members' ICPs and coordinate care for each high risk SNP member.

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