H6764 Indiana University Health Plans NFP, Inc.
Dual Eligible All Dual Special Needs Plan

Model of Care Score: 95.00%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Indiana University Health Plans NFP, Inc. (IUHP) targets individuals eligible for Medicare and full Medicaid coverage who reside in Indiana.

Based on the years of experience with their Medicaid plan, IUHP anticipates that the majority of its members will be white and have some of the following chronic conditions prevalent among the all dual population: hypertension, diabetes, chronic obstructive pulmonary disease, coronary artery disease, congestive heart failure, depression, asthma and serious mental illness.

Provider Network

IUHP's network includes the following facilities: acute care hospitals; long-term care centers, medical centers offering in-patient care services; outpatient centers including dialysis facilities, radiology and diagnostic facilities; urgent care centers; rehabilitation centers; skilled nursing facilities; home care agencies and pharmacies. Additionally, IUHP members have access to the following providers: ancillary providers, behavioral health specialists and medical specialists, clinical pharmacists, durable medical equipment providers, mid-level practitioners and primary care practitioners. IUHP will offer telemonitoring and telemedicine services for unique patient populations through a few of the larger hospitals within the network.

Members have access to participating provider information through multiple sources, including an online provider directory which allows members to enter their zip code and find a desired provider type near them. Additionally, member services representatives are well versed in the network and can help a member by providing information to them over the phone and/or by sending them information upon request.

Care Coordination and Management

Within 90 days of member enrollment, IUHP uses an internally developed health risk assessment (HRA) to gather information on each member's medical and behavioral health conditions, lifestyle risk factors, use of services, access barriers, caregiver support and assistance with daily activities. Reassessments occurs annually and are completed by mail, telephone or in person.

The care manager (CM) uses the information obtained through HRA and claims data to identify the member's acute and chronic care issues, understanding of individualized care including understanding of medications and side effects, access to providers including a primary care physician (PCP) and specialists and barriers to care. In turn, the PCP and the CM work with the

member in establishing patient-centered goals based on identified issues and developing the individualized care plan (ICP). Through ongoing contact with the member, their caregiver and their providers, the CM discusses with the member their progress toward the established goals, identifies new concerns, provides education, coordinates services and identifies community resources that may meet the member's needs.

The interdisciplinary care team (ICT) includes the member, CM, PCP, behavioral health nurse, social worker, pharmacist, nutritionist, diabetic educator, community health worker, medical director and other specialties, depending on the unique needs of the individual. With this structure in place, the CM is responsible for facilitating communication among the member, their caregiver, the PCP, providers treating the member and other members of the ICT by utilizing an internal email system, electronic fax system and electronic care management system.

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://iuhealth.org/medicare/