Care Improvement Plus South Central Insurance Co., R3444
Chronic or Disabling Condition (Chronic Heart Failure and Diabetes) Special Needs Plan

Model of Care Score: 98.75%
3-Year Approval **January 1, 2012 to December 31, 2014**

Target Population

Care Improvement Plus South Central Insurance Company's Chronic or Disabling Condition Chronic Heart Failure (CHF) and Diabetes Special Needs Plan (CIP C-SNP) target population are Medicare enrolled members with CHF and/or diabetes who can be served by a plan with enhanced care coordination in addition to those benefits provided by Medicare. CIP's C-SNP seeks to enroll members who are medically underserved, low income and rural residents. Approximately 50 percent of members are permanently disabled and the average age of the non-disabled membership is 76 years. The median household income is $12,000 and 61 percent of members live at or near the poverty line. Almost two-thirds, or 70 percent, of members did not complete high school and half of members are racial minorities. Currently 84 percent of members have confirmed diabetes and 50 percent have CHF. Twenty five percent are clinically depressed (with only ten percent diagnosed) and each member sees an average of eleven different doctors (yet one in three is medically homeless).

Provider Network

CIP maintains a comprehensive network of inpatient and outpatient providers for special needs populations designed to provide access to all necessary services. The provider directory clearly delineates those who accept Medicaid. Additionally, the CIP open access model means that not only may members self-refer to contracted providers, they may also seek care from any Medicare/Medicaid participating provider who is willing to bill CIP.

Members and providers have access to Therapeutic Resource Centers (TRC) which have more than 1,100 specialist pharmacists trained to provide counseling and education for at-risk members with chronic and complex diseases such as diabetes, high cholesterol, heart failure, hypertension, cancer, asthma and depression.

Medco is the current contracted pharmacy benefit manager (PBM) for CIP. Medco maintains an extensive network of community retail pharmacies and a mail order prescription option. In addition, Medco offers an advanced clinical pharmacy model. CIP offers access to a mental health network, in partnership with Optum Behavioral Health that includes counseling, inpatient and outpatient services. The CIP behavioral and mental health network includes: psychiatrists,

clinical psychologists, clinical social workers, addiction specialists and mental health field workers who work with members in the home setting.

Care Management and Coordination

CIP utilizes multiple strategies to complete the initial health risk assessment (HRA) within 90 days of enrollment and an annual re-assessment within one year of the last assessment. An initial face-to-face comprehensive HouseCalls visit by a physician or nurse practitioner (NP) is the preferred method. If it is not possible to schedule the HouseCalls visit within the first 90 days or if the member declines the visit, a telephonic HRA is conducted. The HRA focuses on medical, psychosocial, cognitive and functional needs. The co-morbidities associated with cardiovascular disease are targeted and the HRA helps detects complex diagnoses such as CHF, diabetes, cancer, chronic obstructive pulmonary disease (COPD), cognitive impairments and others.

HRA findings allow for the comprehensive identification and prioritization of problems and interventions within the plan of care (POC). Upon completion of the initial and annual assessments, it is determined if the member is eligible for other CIP clinical programs. Members are also stratified into risk levels based on the assessment results and are assigned a specialized interdisciplinary care team (ICT) according to identified need as determined through initial and ongoing assessments. Core members of the ICT will remain consistent while additional members may participate for limited time frames to address specific identified needs.

The core members of the ICT include the member, the member's personal physician, the nurse care manager, the clinical pharmacist and the HouseCalls practitioner. Additional members such as a caregiver, social worker, behavioral health professional, specialty physicians, ancillary health and community based professionals, nutritionists, home health professionals, rehabilitation specialists, physician specialists, community health care workers, pain management specialists, palliative care and hospice professionals, transitions care managers, respiratory therapists and utilization management nurses may be added to the ICT according to assessed needs as reflected in the POC.

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: https://www.careimprovementplus.com/