R9896 Care Improvement Plus,
Chronic or Disabling Condition (Chronic Heart Failure and Diabetes) Special Needs Plan

Model of Care Score: 99%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population
Care Improvement Plus (CIP) is a subsidiary of UnitedHealthcare and almost 50 percent of its population is comprised of members who are permanently disabled. Additionally, the average age of its non-disabled membership is 76. Sixty-eight percent of CIP's members have not completed high school and more than 77 percent of them live in rural counties. Almost 45 percent of these members are African American or Hispanic (many with language barriers); also approximately 65 percent receive low income subsidies. These members have an average Hierarchical Condition Category (HCC risk score) of 1.76 and the plan experiences an average of 500 admissions per 1000 within the first year of enrollment. Sixteen percent of members experience 30-day all cause readmissions and the majority take 11 to 14 unique prescriptions.

Provider Network
CIP maintains a network of inpatient and outpatient providers for special needs populations designed to provide access to services that members may need. The provider directory delineates who accepts Medicaid. Additionally, CIP has an open access model. Members may self-refer to contracted providers and seek care from any Medicare/Medicaid participating provider who is willing to bill CIP. The plan determines active licensure and provider competency when it receives a provider's initial application for participation as well as on an on-going basis.

Care Management and Coordination
CIP utilizes multiple strategies to complete an initial assessment within 90 days of enrollment and an annual reassessment 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, CIP attempts to conduct a health risk assessment (HRA) by phone. The HRA focuses on the assessment of medical, psychosocial, cognitive and functional needs. Physicians, registered nurses and pharmacy experts (with input from statisticians, actuarial and mathematical professionals) develop stratification algorithms. At the conclusion of the HRA, the clinician discusses any urgent care issues that need to be addressed in a timely manner with the member and caregiver.

The nurse care manager also shares relevant information from the HRA and other member assessments with the interdisciplinary care team (ICT) team members. CIP utilizes evidenced based guidelines to structure disease-specific, functional and psychosocial individualized plans of care (POC) for members. The nurse care manager initiates the creation of the POC following intensive review of the HRA, disease-specific assessments, administrative claims, pharmacy data and other data from the HouseCalls assessment. All available data, as well as the member's verbalized health needs and goals, drive the initial population of the POC. ICT members can revise the POC at any time and the nurse case manager monitors the POC. The ICT and nurse case manager review the POC with the member following each encounter and when significant enhancements or updates are recommended by the primary physicians and appropriate members of the ICT.

The plan carefully selects the members of the virtual ICT for each member. 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 may be added to the ICT according to assessed needs as reflected in the POC. Prior to crafting the ICT, the nurse care manager reviews the roles and responsibilities of each ICT team member to ensure the member and caregiver understand and are in agreement with the service. Following each encounter with the member, the ICT communicates findings, which are documented in the member's POC. Members and caregivers are encouraged to give feedback to the ICT at any time.

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 member needs. For more information about this health plan refer to the Special Needs Plan's website at:
https://www.careimprovementplus.com/