The following list of services, delivered by our IbisCare program, are based on services required for the Comprehensive Primary Care Plus[[1]](#footnote-1) program. The cost reflects monthly, per member fees to cover the cost of the service. This program is expected to generate significant savings for the costliest 10% of the population. As such, Senscio’s profits from this program will be through a shared savings arrangement.

|  | Ibis Service for Intensive Care Management Service | Cost |
| --- | --- | --- |
| Access and Continuity | Ensure members have 24/7 access to a care team practitioner with real-time access to the EHR. | $20 pmpm |
| Regularly offer at least one alternative to traditional office visits to increase access to care team and clinicians in a way that best meets the needs of the member, such as e-visits, phone visits, group visits, home visits, alternate location visits (e.g., senior centers and assisted living centers). |
|  |  |  |
| Care Management | Use a two-step risk stratification process for all empaneled patients:  *Step 1 -* based on defined diagnoses, claims, or another algorithm (i.e., not care team intuition);  *Step 2 -* adds the care team’s perception of risk to adjust the risk-stratification of patients, as needed. | $100 pmpm + FFS for medication reconciliation after hospital discharge + FFS for post discharge home visits if needed |
| 100% of members are assigned to care teams within 7 days of enrollment. |
| Provide targeted, proactive, relationship-based longitudinal care management to all members. |
| Coordinate timely interventions, as indicated by Ibis, with primary care, specialists, and social support providers. |
| Ensure hospitalized members receive a follow up interaction within one week of discharge. |
| Contact at least 75% of members who were hospitalized in target hospital(s), within 2 business days. |
| Update care plan following every hospitalization. |
| Use a plan of care centered on member’s actions and support needs in management of chronic conditions. |
|  |  |  |
| Comprehensiveness and Coordination | Systematically identify high- volume and/or high-cost specialists serving the member population using CMS/other payer’s data, and coordinate interventions with those specialists. | $10 pmpm + FFS for 4 home visits per year |
| Identify hospitals and EDs responsible for the majority of members’ hospitalizations and ED visits, and coordinate discharge from those hospitals. |
| Remotely monitor and assess health, including behavioral health |
| Systematically assess patients’ psychosocial needs using evidence- based tools. |
| Maintain an inventory of resources and supports to meet patients’ psychosocial needs. |
| Characterize important needs of sub- populations of high-risk patients and identify a practice capability to develop that will meet those needs, and can be tracked over time. |
|  |  |  |
| Patient and Caregiver Engagement | Implement self-management support for majority of conditions for all members. | $20 pmpm |
| Convene at least two meetings with member and family per year and integrate recommendations into care, as appropriate. |  |
|  |  |  |
| Planned Care and Population Health | Use feedback reports provided by CMS/other payers at least quarterly on at least 2 utilization measures at the practice-level and practice data on at least 3 electronic clinical quality measures (derived from the EHR) at both practice- and panel-level to inform strategies to improve population health management. | $10 pmpm |
| Create weekly reports on population health for all members. |
| Participate at care team meetings at least weekly to review practice- and panel- level data from payers and internal monitoring and use this data to guide testing of tactics to improve care and achieve practice goals. |

1. <https://innovation.cms.gov/initiatives/comprehensive-primary-care-plus> [↑](#footnote-ref-1)