Health Net of Arizona, H0351
Chronic Condition (Cardiovascular Disorders) Special Needs Plan

Model of Care Score: 93.13%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

The population targeted for Health Net's Special Needs Plan (SNP) is Medicare members that have one or more of the following cardiovascular disorders: cardiac arrhythmias, coronary artery disease, peripheral vascular disease and chronic venous thromboembolic. Health Net's SNP members reside in one of the following Arizona counties: Maricopa, Pima or Pinal.

Provider Network

As Health Net offers a chronic condition special needs plan, it maintains a comprehensive network of primary care providers, facilities, specialists and ancillary services for SNP members. Health Net contracts with a full range of providers and vendors including acute care hospitals, home health care companies, infusion therapy and dialysis companies, durable medical equipment vendors, outpatient surgery facilities, radiology/imaging centers, skilled nursing facilities, acute and sub-acute rehabilitation facilities, mental health/chemical dependency providers, laboratory services, outpatient pharmacies, and hospices.

Care Management and Coordination

Health Net conducts an initial health assessment and annual reassessment of each SNP member's physical, psychosocial, and functional needs. The results are evaluated by the interdisciplinary care team (ICT) to develop or update the member's individualized plan of care (ICP). Telephone outreach to complete the health risk assessment (HRA) with new SNP members occurs within 90 days of member enrollment, upon member health status changes and at least annually. Case managers may revise the member's stratification during assessment or reassessment.

Care is coordinated for SNP members through an ICT to address medical, cognitive, psychosocial and functional needs. Each SNP member is assigned to an ICT appropriate for the member. The member and/or caregivers are encouraged to participate on the ICT. The case manager will encourage member participation verbally and/or in writing by informing the member of the meeting time and providing contact information when appropriate. The ICT is responsible for overseeing, coordinating, and evaluating the care delivered to assigned members. The ICT is composed of primary, ancillary, and specialty care providers.

At a minimum, the ICT members include: a medical expert (e.g., primary care physician, specialist, or registered nurse care/ case manager), behavioral and/or mental health specialist (e.g. psychiatrist, psychologist, or drug or alcohol therapist) when indicated, social services expert (e.g., social worker, or community resource specialist). Additional ICT members may include: a pharmacist, restorative

health specialist (e.g., physical, occupational, speech, or recreational therapist), nutrition specialist (e.g., dietician or nutritionist), health educator (nurse educator) disease management specialist (e.g., preventive health or health promotion specialist) and caregiver/family member and pastoral care.

The Case manager determines the membership of the ICT based on the member's medical, psychosocial, cognitive and functional needs identified through the HRA and initial assessment. The care/case manager works collaboratively with the ICT, member/caregiver and the member's provider(s) to develop an individual documented plan of care incorporating information from the HRA, member assessment and other sources. The care/case manager identifies specific individual problems or concerns, in collaboration with the ICT, to establish long term and short-term goal setting to meet the member's needs. Each problem will be documented with a problem statement in the medical management system and have at least one goal and one intervention. As part of the monitoring process, the care/case manager contacts the member or authorized representative and providers at established timeframes based on specific interventions and/or the care/case manager's clinical judgment. Contacts should be at the minimum frequency as defined by the member's acuity level.

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.healthnet.com/portal/shopping/content/iwc/shopping/medicare/introduction.action