H0351 Health Net Jade of Arizona
Chronic or Disabling Condition (Chronic Heart Failure and/or Diabetes) Special Needs Plan

Model of Care Score: 88.33%
3-Year Approval **January 1, 2015 – December 31, 2017**

Target Population

Health Net Jade's chronic or disabling condition special needs plan (C-SNP) for diabetes and congestive heart failure (CHF) provides healthcare services for residents residing in Maricopa and Pinal counties, Arizona. Maricopa County represents the largest population-dense county and houses the Phoenix metropolitan area, which consists of 20 contiguous municipalities and three tribal communities.

Jade SNP's specific demographic information indicates members are roughly 72 years of age, which is younger than the overall Medicare population as a whole. Women make up the majority of the SNP population at 59 percent, with 41 percent being male. The Arizona SNP ethnic population consists of 96.1 percent White, 2.7 percent Black, 1.7 percent Asian American/Pacific Islander and 0.4 percent Native Hawaiian. Out of these ethnicities, 16.2 percent of members self-identify themselves as Hispanic or Latino.

Health Risk data shows that 42 percent of Jade SNP members cannot shop for their own food, while 41 percent of members report that they cannot cook their own food. Transportation also acts as an economic factor that contributes to members having difficulty getting to doctor appointments, picking-up prescriptions and attending social events. Roughly, 26 percent of SNP members depend on friends for transportation. As a result of this, 50 percent of members report that they are unable to participate in social activities on a regular basis

Provider Network

Health Net maintains a network of primary care providers, facilities, specialists and ancillary services to meet the needs of members and treat conditions such as diabetes, cardiac disorders, respiratory problems, musculoskeletal, neurological disease and behavioral health disorders. The plan also contracts with a full range of providers and vendors including acute care hospitals, home health care companies, infusion therapy, 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 hospice services.

Care Coordination

Care coordination for all members begins with Health Net conducting an initial comprehensive health risk assessment (HRA) for new SNP members. Evaluations occur within the first 90 days of enrollment, after a change in health status or annually thereafter. The HRA assessments are

performed by phone, electronically or through mail when the member cannot be reached. . The assessment includes a comprehensive set of questions designed to assess medical and mental health history, psychosocial, functional and cognitive needs.

The plan uploads HRA responses to the electronic medical management system for internally managed members and to a provider portal for delegated members. The plan evaluates the results of the HRA to determine individual members' needs and assist with developing or updating an individual care plan (ICP). In addition to the HRA driving the ICP, the case manager also engages with the member to gain input into the care planning process and establish health goals.

Once problems, goals and interventions for the care plan are established, the plan reaches an agreement with the member to develop an interdisciplinary care team (ICT) that implements the ICP and develops timelines for follow-up. The plan documents the approved ICP in the member's record and houses it in the health records system so that all internal ICT members have access to it. The plan coordinates all care for members through the ICT to address medical, cognitive, psychosocial, and functional needs. Responsibility for coordinating, evaluating and updating the care plan ultimately rests with the ICT. The ICT monitors the individual member's progress towards goals and health outcomes to modify interventions and adjust ICT membership as needed. At minimum the composition of the ICT includes, medical experts, social services, behavioral/mental health and additional specialists as needed.

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
Enter a zip code for California, Arizona or Oregon and select Special Needs Plans