Network Health Insurance Corporation H5215
Dual Eligible (All Dual) Special Needs Plan

Model of Care Score: 88.13%
3-Year Approval **January 1, 2013 to December 31, 2015**

Target Population

Network Health Insurance Corporation (NHIC) offers a Dual Eligible Special Needs Plan called Network*Cares,* to individuals in all Medicaid eligibility categories, who also receive benefits under Medicare parts A and B and live within 16 Wisconsin counties. This population includes individuals who are: diagnosed with multiple chronic illnesses, at or near the end of life and low-income. These members are typically frail or disabled, have minimal family support and have high utilization of the emergency room. In addition, they often have medication compliance issues, dietary issues and transportation concerns.

Provider Network

NHIC contracts with: medical, behavioral health and pharmacy networks, cancer centers, transplant centers, rehabilitation facilities, a Myalgia Therapy Center, and specialists in pain management, hospice, dialysis, dentistry, retina/vitreous disease, endocrine, diabetes, lipidology, acupuncture, addiction psychiatry, arrhythmia monitoring, cardiac monitoring, geriatric medicine, hyperbaric, integrative medicine, neuropsychology, physical medicine and rehabilitation, rehabilitation psychology, rheumatology, sleep medicine, wound and ostomy care and wound vac therapy.

Network*Cares* operates under a primary care model. The primary care physician/practitioner (PCP) is responsible for directing and coordinating specialty care. The SNP encourages members to select a PCP upon enrollment who coordinates their care with specialists however they are not required to do so. PCPs may be of any specialty, although members are encouraged to select medical home providers as their PCPs.

Care Management and Coordination

NHIC uses several tools for initial and annual health risk assessments (HRA). All new members receive a health plan developed HRA form by mail. Annually each member also completes a similar version of this tool, by phone.

Areas covered in both assessments include: medical/clinical diagnoses and utilization (e.g., chronic conditions, emergency room visits, hospitalizations, and medications), psychosocial issues (living situation, behavioral health needs, social and economic needs), functional status (activities of daily living, safety) and advance directives. Depending on level of support within the community and existing need, a nurse or social worker completes an initial complex case management assessment or an initial coordination of services assessment. Network*Cares* assigns

each member to a coordination of care, complex case management or monitoring passive case management case group upon enrollment.

The SNP uses information gathered from all HRA tools to formulate and update each member's individualized care plan (ICP). All members are assigned a care management coordinator (CMC), or social worker who is responsible for the care plan and for supporting the member through transitions in care. Care plans include goals related to: risks for transition monitoring, gaps in care monitoring, completion of an annual HRA –within the third or fourth quarter, program referrals, transitions in care communication plans, and provider and community care partner communication plans.

Care plans for members in the coordination of care and complex care case groups also encompass: short-term and long-term goals, follow-up on barriers to meeting goals, condition monitoring – red flags, activation of advance directives, resources to be utilized by member including appropriate level of care and an adequate number of direct access visits to specialists, collaborative approaches including member and family participation and follow-up communication plans. At least every three months, the CMC or social worker develops, updates, and implements the care plan with the member/responsible party. More frequent reassessment can occur based upon high risk identification or a need to assist in transitioning the member from inpatient level of care to lower level of care.

Each member has an interdisciplinary care team (ICT). Since the level of need varies within the population, ICT composition will vary depending on the needs of the member. The core ICT consists of the assigned CMC or social worker, PCP, health care concierge (HCC) and the member/member representative. Depending on the individual member's situation, some become permanent members of the ICT while others are included on an as needed basis.

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: www.networkhealthmedicare.com