H5580, Southwest Catholic Health Network Corporation
Dual-Eligible (Dual Eligible Subset) Special Needs Plan

Model of Care Score: 78.12%

2-Year Approval **January 1, 2014 – December 31, 2015**

Target Population

Southwest Catholic Health Network Corporation serves dual eligible members who are enrolled in Medicaid through the state of Arizona, are eligible for Medicare Part A and B and also reside in the plan's service area. Plan members are often frail, elderly, and coping with disabilities. These members have compromised activities of daily living, chronic co-morbid medical and behavioral illnesses, challenging social or economic conditions, and end-of-life issues. On average, most members have an annual household income equal to or less than $19,999. The Medicaid program, known as Arizona Health Care Cost Containment System (AHCCCS), serves a sub-population of members who are qualified for the Acute Care program, the elderly and physically disabled (EPD) who qualify for Arizona Long Term Care Services (ALTCS) and members with developmental disabilities (DD) enrolled in ATLCS/DD.

Provider Network

The Southwest Catholic Health provider network is comprised of primary care physicians and specialty providers whose primary focus is treating chronic illnesses. These specialties include but are not limited to cardiology, nephrology, pain management, pulmonology, geriatrics, infectious disease, oncology, endocrinology, rehabilitation, nurse practitioners, registered nurse, nurse managers, nurse educators and behavioral health professionals (psychiatrists, psychiatric nurse practitioners, clinical psychologists and social workers). Inpatient acute care, long term care and rehabilitation services are provided by the large network of hospital systems that includes, Carondelet Health Network, Dignity Healthcare (formerly Catholic Healthcare West), Banner Health and Abrazo Health Care. The organization also provides specialty outpatient and ancillary services such as laboratory, radiology/imaging, ambulatory surgery, dialysis, home health, infusion, durable medical equipment, pharmacy and physical, speech and occupation therapy. In addition, the organization contracts with Federally Qualified Health Centers (FQHC) and Rural Health Clinics (RHC), which are clinics within the member's local community that can provide health, behavioral and social services.

Care Management and Coordination

The health risk assessment tool (HRAT) collects data related to medical needs, functional status, cognitive status and psychosocial status of the members and is completed within 90 days of enrollment and annually thereafter. The HRAT is completed by telephone and the results are then discussed with the interdisciplinary care team (ICT) in order to develop an individualized care plan (ICP). Members who are in the ATLCS have ICPs that are updated within 12 days of enrollment and updated every 90-180 days.

The ICT composition reflects the need for a multi-specialty approach and includes a plan medical director, behavioral health medical director, behavioral health coordinator, and the case manager who is actively working with the member. Other departments, such as concurrent review or prior authorization, are invited as needed. Inclusion of the primary care physician, other ancillary personnel, the member and caregiver are highly desired and can be coordinated by the case manager. Outcomes and recommendations are communicated to the member by the case manager. Meetings are held weekly or bi-weekly and usually conducted in person and by telephone. The case manager is considered to be the member's liaison and will be the member's representative for when they cannot attend meetings.

The ICP is created utilizing information collected from the HRAT, comprehensive medical evaluation, review of medical records, provider diagnoses and utilization data. It is used to identify the member's health care goals and objectives, activities and services which the member agrees upon to improve and attain optimal health outcomes. The measureable outcomes are communicated to the primary care physician who can also provide feedback and request further discussion if needed. For low-risk members, the plan's system will create an ICP that is more basic and will include topics such as smoking cessation, exercise or other basic health tips. The ICP is updated annually or when there is a change in the member's health status.

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: http://mercycarehealthplans.com, select "Seniors/Medicare."