H2491 WellCare Health Insurance Company of Arizona Inc.
Dual Eligible (Subset- Medicare Zero Cost Sharing) Special Needs Plan

Model of Care Score: 100.00%
3-Year Approval **January 1, 2015 to December 31, 2017**

Target Population

WellCare Health Insurance of Arizona, Inc. (‘Ohana Health Plan, Inc. (‘Ohana)) is a federally approved dual eligible special needs plan (D SNP) managing health care services for the underserved and culturally diverse Medicare and Medicaid recipients of Hawaii. As of December 2013, ‘Ohana had 6,836 members of which 62 percent were 65 years or older. About 58 percent of members are female. The majority of the members are racial or ethnic minorities (Hawaiian Chinese, Filipino and Hawaiian) however, most speak English as their primary language.

High member hospitalization costs are associated with members suffering strokes, septicemia, schizophrenia, congestive heart failure (CHF), psychosis and cardiac diseases. The top diagnoses among members are diabetes, hypertension, respiratory disorders and psychosis. About 57 percent of members have two or more health care conditions and 11 percent have a behavioral health condition. ‘Ohana’s overall D SNP membership faces multiple medical, cultural, socioeconomic and linguistic challenges. Many members have multiple chronic and debilitating conditions, which have a direct impact on their quality of life and ability to obtain needed care.

Provider Network

‘Ohana maintains a comprehensive network of multidisciplinary practitioners and ancillary providers to meet the extensive acute, chronic and preventive medical, surgical, behavioral and psychosocial needs of the dual-eligible special needs population. Specialist providers are available to serve the clinical needs of the member population. Services are available in the home, community and hospital settings.

Care Management and Coordination

The health risk assessment (HRA) provides an opportunity to offer case management services to D SNP members. HRAs are conducted for all members within 90 days of enrollment and again annually, within 365 days of the previous HRA, or more frequently as needed. Based on the initial HRA, ‘Ohana stratifies its members according to level of health care need from high to low, high being the most vulnerable.

In addition to the HRA, the case manager (CM) completes a comprehensive assessment with the member and discusses the results of the HRA including stratification level and meaning of stratification, utilizing all information available to develop the initial individualized care plan (ICP). The ICP is the primary vehicle for communicating HRA information along with information from other sources and interactions. The ICP identifies goals and services that reflect the member's unique needs and is shared with the interdisciplinary care team (ICT), which reviews and provides feedback.

The CM has primary responsibility for coordinating all aspects of a member's care by partnering with the PCP to manage care across medical providers. During a transition, the CM ensures that changes in care, medications and treatment are communicated to caregivers and physicians and ensures all necessary care is scheduled and provided. The CM serves as the member's advocate, making sure that new settings and providers have current treatment information and that necessary services are delivered. The ICP reflects changes and updates to a member's treatment. Planned and unplanned transitions are tracked using manual and system generated reports. These reports alert CMs of unplanned transitions (e.g. inpatient admissions) so that members of the ICT are notified and treatment needs reassessed for development of a member specific transition plan. The member's ICP incorporates the transition plan and includes input from providers prior to and post-transition, as well as the treatment protocols in the new setting.

The CM, in consultation with the medical director, as needed, determines the membership of the ICT based on individual member needs and team requests for additional specialists. The composition of the ICT varies for each member, however core participants include, internal health plan staff; external members such as vendors, community representatives and external providers. Other members include but are not limited to the behavioral health medical director, utilization management (UM) nurses, CMs, care management coordinators and pharmacists. The CM shares the ICP with members of the ICT for review, and goals/targets are updated accordingly based on new information. This occurs, at a minimum, during initiation of the ICP and at any significant 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 beneficiary needs.

For more information about this health plan refer to the Special Needs Plan's website at: https://www.ohanahealthplan.com/medicare/SNPs