H4931 University Care Advantage Inc.
Dual Eligible Special Needs Plan

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

Target Population

University Care Advantage (UCA) will serve the health care needs of dual-eligible members residing in the Central and Southern Arizona counties beginning January 2015. As of January 1, 2013 UCA had 3,615 members. UCA will serve members in the following Medicare/Medicaid subsets to the extent to which they exist within Arizona: Medicaid Only, QMB, QMB+, SLMB, SLMB+ and QI.

More than 50 percent of UCA members are younger than 65. About one-third of member are Latino and 20 percent of members primarily speak Spanish. Almost 80 percent of members earn less than $19,999 a year. Members' literacy level is low, they exhibit poor hearing and report poor mental and physical health. There are high rates of chronic and behavioral conditions, including high rates of co-morbid conditions. Most members live in urban counties of Arizona, however one-third of members live in rural areas and experience poor access to specialty care.

Provider Network

UCA has a network of contracted providers including medical specialists, sub-specialists, inpatient facilities, dialysis facilities, pharmacies, primary care physicians (PCP), nursing professionals, outpatient clinics, durable medical equipment (DME) vendors, behavioral health professionals and other health services providers. To obtain a real time listing of the providers within the network, members and providers can visit www.ufcaz.com to view the provider directory. The network also includes providers who specialize in areas such as endocrinology, cardiology, nephrology, psychiatry, geriatrics, HIV, transplants and behavioral health.

Care Management and Coordination

UCA utilizes a comprehensive health risk assessment (HRA) tool to measure a member's physical health, cognitive status, medication regimen, medical history, surgical history, behavioral health status, cultural preferences, linguistic needs, pregnancy state, nutritional status, functional and psychosocial needs. Members complete an initial assessment and annual re-assessment. Care management staff use the results to work with the member, the PCP and the interdisciplinary care team (ICT) to develop an individualized plan of care (ICP).

Members are stratified into the appropriate risk level based on HRA responses. The member is assigned to a care management specialist (CM specialist), if scored initially as low or moderate risk, or to a care manager (CM) if scored as high risk initially.

The CM reviews the ICP with the member while the plan is being developed and periodically to ensure that the ICP continues to meet the member's needs. Follow up depends on the member's specific condition. The CM will follow up for appointments and when there are prior authorization requests. This ensures the member keeps appointment(s) and receives services in a timely manner. Follow up is weekly, monthly, quarterly or annually. If the ICT makes changes to the ICP, they are discussed with the member and/or member designee. The CM must also notify the PCP of any changes to the ICP.

The ICT consists of the SNP CM, the SNP care management manager, the medical director, behavioral health case managers, disease case management and adult/catastrophic case management and member. The pharmacy director or designated staff, customer care, network development, and marketing personnel may be invited as needed. A member's ICT is led by a clinician case manager (registered nurse (RN), clinical or licensed social worker (CSW or LCSW)) who is responsible for the development, tracking and updating of the ICP. Other ICT members can include provider network staff, case management specialists, a pastoral counselor, specialists, health educators, disease managers, pharmacists and/or a family member/caregiver. These individuals help the CM develop or update the member's ICP. The ICT meets twice weekly to support the member's care transitions and care management needs.

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: