ONECARE by Care1st HP of AZ, H5430
Dual Eligible (Dual Eligible Subset - Medicare Zero Cost-sharing)
Special Needs Plan

Model of Care Score: 96.88%
3-Year Approval **January 1, 2014 –December 31, 2016**

Target Population

ONECARE by Care1st Health Plan Arizona, Inc. (ONECARE or the Plan) is a Full-Benefit Dual Eligible Special Needs Plan (D-SNP). There is a significant burden of chronic disease and disability among this population. The most prevalent chronic conditions are: diabetes and its complications, cardiovascular diseases, hypertension, respiratory conditions (e.g., asthma and COPD), and hyperlipidemia. Multiple concurrent or comorbid conditions are often present in the same individual with approximately 33 percent suffering from behavioral health and substance abuse conditions. ONECARE members may also face challenging social and economic situations, such as lack of emotional and social support and residential instability, which frequently impairs their ability to adhere to treatment plans and to fully benefit from them.

Provider Network

ONECARE's provider network is comprehensive and includes hospitals, ambulatory surgical centers, urgent care centers, allied health professionals such as physical, occupational and speech therapists, outpatient lab, radiology/imaging services. There is a large primary care network, including family practitioners, internal medicine providers, pediatricians and primary care focused nurse practitioners, physician assistants and all specialties including but not limited to geriatricians, HIV specialists, cardiologists, endocrinologists, and pulmonologists.

Care Management and Coordination

The health risk assessment (HRA) tool is evidenced based, and is adapted from the Arizona Department of Elder Affairs assessment. The HRA assesses the member's medical history, current condition(s), behavioral health history and needs, ability to perform Activities of Daily Living (ADL's), health risk factors, current medication usage, use of the primary care physician (PCP), any referred specialists, ancillary services, and durable medical equipment (DME) use. The member's primary language, living situation, and the availability of in-home help or care giving resources, if needed, are also assessed. Plan benefits are explained to the member during the assessment. Referral to any appropriate outside resources are given verbally or by letter. The

HRA is repeated on an annual basis or sooner if a change in the member's health care needs are identified.

The member/caregiver is engaged through the assigned care coordinator or case manager who initiates contact. The care coordinator and/or case manger use the HRA to stratify members into one of three risk levels (low, moderate or high) and establish contact intervals based on their assigned risk level. Depending upon the severity of triggering events and member risk level, reevaluation of the individual care plan (ICP) may occur monthly or quarterly; however, frequency may also change based on the member's needs. The original care plan and all modifications to it are communicated to the beneficiary, caregiver (as available) and providers.

The interdisciplinary care team (ICT) includes the following ONECARE staff: chief medical officer (CMO), nurse case/disease managers, behavioral health supervisor and coordinators, utilization management/case management (UM/CM) manager, care coordinators, social workers, pharmacy staff and quality management nurse specialists. External individuals may include: a social worker with the Area Agency on Aging (AAA), behavioral health provider, member and/or caregiver/family, PCP and/or specialists, and care level management (CLM) staff (physician or nurse practitioner if the member is seen in the home). Depending on the needs of the member, other health care or pastoral services representatives may be included in the ICT, as identified during team meetings. It is the responsibility of the ICT in conjunction with Information Systems management, to provide clinical oversight of functions that relate member identification, stratification, health improvement, coordination of care, development and ongoing monitoring of the ICP, evaluation of outcomes and development of corrective action plans. Case managers are responsible for coordinating services across the health care continuum and for ensuring the ICP is communicated to the ICT member/caregiver and all providers involved in the ICT.

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.care1st.com/az/healthplans/onecare.asp.