H5433 Orange County Health Authority
Dual Eligible (Dual Eligible Subset-Medicare Zero Cost-sharing) Special Needs Plan

Model of Care Score: 96.67%
3-Year Approval **January 1, 2015 to December 31, 2017**

Target Population

The CalOptima OneCare HMO SNP (OneCare SNP) program provides health care services to seniors and persons with disabilities (SPDs). OneCare SNP members reside in Orange County California and receive services from Medicare Part A and Part B and Medi-Cal through CalOptima's Contract with the Department of Health Care Services (DHCS).

The OneCare SNP program serves a highly vulnerable population, which includes the frail elderly, the disabled, those with multiple chronic conditions and mental health needs. Members have language barriers, limited family or social networks and housing needs. As of January 1, 2014, OneCare SNP served a population of 16,121 members. Sixty-three percent of OneCare SNP members are 65 years of age or older and about 40 percent of the members are classified in a Medicaid Aid Code Category of disabled. The majority of members are Hispanic/Latino descent (27.1 percent) and female (53.9 percent). The OneCare SNP population speaks English (50 percent), Spanish (27 percent), Vietnamese (13 percent) and Farsi (1 percent). In 2013, diabetes, depression and kidney disease were the most prevalent conditions associated with utilization by OneCare SNP members.

Provider Network

The OneCare SNP provider network consists of primary care physicians (PCP) and specialists including, but not limited to cardiologists, oncologists, nephrologists, general surgeons, geriatricians, gynecologists, ophthalmologists, orthopedic surgeons, psychiatry, neurologists and pain management specialists. The network also includes hospitalists to manage members' inpatient needs, a skilled nursing facility (SNF) specialist who manages the needs of members in a SNF, nursing staff, allied health providers (nurse practitioners, physician assistants, pharmacy techs, optometrists, etc.), mental/behavioral health providers, a pharmacy network and ancillary providers (home health agencies, durable medical equipment vendors, etc.)

For some tertiary specialty facilities, OneCare SNP contracts with regional centers of excellence to provide specialized services in the following settings: acute facilities, dialysis centers, post-acute hospital facilities, specialty out-patient clinics, rehabilitation facilities, radiology/imaging facilities and labs.

Care Management and Coordination

OneCare SNP uses a health risk assessment (HRA) tool to conduct an initial and annual assessment of OneCare members. The HRA ensures timely identification of acute, chronic, behavioral health, long term support services (LTSS), access and care coordination needs along with health and wellness promotion. The HRA facilitates identification of additional assessments of members' physical and mental health, substance use, incapacity in key activities of daily living, dementia, cognitive status and the capacity to make informed decisions. It serves as an adjunct to a history and physical.

OneCare Personal Care Coordinators (PCCs) encourage and facilitate the HRA completion. HRA responses are scored and used to stratify members into high, medium and low risk levels. Members are also translated into a system of domains, which provides the framework for development of the initial individualized care plan (ICP), triggers further investigation and identifies the composition of the interdisciplinary care team (ICT).

The ICP includes the risk stratification level, recommendations for referrals and appointments, preventive care, early detection screening studies, medication reconciliation, community resources, home service resources, disease management and health education and/or dietary consultation. Low risk members are managed in basic case management by a PCP level ICT. Moderate risk members are managed in care coordination by a physician medical group (PMG) level ICT. High risk members are managed in complex case management by a PMG level ICT.

The PCP is the gatekeeper and leads the basic ICT. The PCP works collaboratively with the member and specialists to ensure timely access to quality care. The ICT includes the member, if feasible, PCP, specialist, medical director, case manager and social worker. With a member's consent, family, caregivers and authorized representatives are invited to participate. A behavioral health specialist, dietician, LTSS coordinator, utilization managers, facility discharge planners, therapists and community based organizations may also participate.

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.caloptima.org/en/Members/OneCare.aspx