Health Choice of AZ H5587
Dual Eligible (Subset) Special Needs Plan

Model of Care Score: 86.25%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

Health Choice Generations HMO (Health Choice) is a Special Needs Plan with prescription drug coverage. The contract with Medicare includes two plan benefit packages; a Full Dual SNP and a Medicaid Subset Dual SNP. This SNP is designed to meet the needs of individuals who receive State Medicaid benefits. All eligible members have Medicare A, B, and D, and receive full Medicaid benefits. While most members in this target population have at least one or more chronic conditions, 11 percent have two or more conditions and 5.87 percent have three or more conditions, such as respiratory, cardiac and metabolic conditions. The majority of these chronically ill enrollees are severely challenged in managing their condition due to complex, socioeconomic barriers and behavioral health conditions.

Provider Network

Health Choice's provider network reflects contracted physicians who offer primary care and specialty services, as well as additional care providers who offer a full-range of geriatric programs, hospitals, acute care, post-acute care rehabilitation, long term care services, and home and community based services. Network specialists can be accessed directly for care, and specialized needs are coordinated for each member through their assigned care navigator or clinical care manager. Health Choice's network monitoring activities include assessment and evaluation of network adequacy.

Care Management and Coordination

The health risk assessment (HRA) is completed within 90 days of enrollment and annually thereafter. It addresses the full aspect of the member's overall health and wellness including medical and mental health status, functional level, cognitive functioning, psychosocial, medication history and adherence, activities of daily living, any recent services (e.g., physical therapy, home health) or hospitalizations, and their socioeconomic status. The HRA is designed in collaboration with a multi-disciplinary team of Health Choice staff from the medical management, quality management, and compliance departments. The HRA is available in alternative formats or languages upon identification of any special needs, cultural/language needs, or upon member request. For members with chronic conditions or identified as needing special assistance, specialized case management or transition of care programs, Health Choice

facilitates an additional Home Assessment Program, which complements the HRA by providing an in-depth assessment of member-specific conditions and needs, and documents identified acute and chronic health problems.

Once the initial HRA and concurrent clinical case management assessments are completed, the clinical case manager collaborates with the member and/or the member's family/caregiver, and the primary care provider (PCP) to create an individualized care plan (ICP). The ICP incorporates the member's personal preferences and feedback, identified service needs, presenting chronic conditions, screenings, current symptoms, medication adherence, problem assessment and identification of strengths to meet the identified goals within the care plan.

The interdisciplinary care team (ICT) assists with the development of the member's ICP. The team is composed of primary, ancillary and specialty care providers who are involved in the management of the member's chronic medical and/or behavioral health conditions along with health plan representatives from various disciplines. The ICT further assists the member in identifying appropriate providers and facilitates access to services throughout the continuum of care using the resources and services required by the member. The ICP is updated with the member's identified ICT and the member at least annually or as needed based on progress towards goals and/or changes in the member's current health status. This allows the ICT to promptly address any concerns or identify barriers toward achieving goals, and implement any interventions to re-align goals to maximize outcomes.

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: www.healthchoicegenerations.com