SECTION I: Introduction

WELCOME

We would like to welcome you to ONECare by Care1st Health Plan Arizona, Inc. (ONECare). As a provider you play a very important role in the delivery of health care services to our members.

The ONECare Provider Manual is intended to be used as a guideline for the provision of covered services to ONECare members. This manual contains policies, procedures, and general reference information, including minimum standards of care which are required of ONECare Providers.

As a ONECare Provider, we hope this information will help you better understand how ONECare operates. This Manual is applicable to the ONECare line of business only, which pertains to members who qualify for both Medicare Part A and B in conjunction with AHCCCS (sometimes referred to as Medicare Advantage Special Needs Plan). Should you or your staff have any questions about any information contained in this manual or anything else about ONECare, please feel free to contact our Provider Network Operations Department at any time. See Section II for phone numbers for your Provider Network Operations Department and for other departments that you may need to contact.

ONECare works closely with our contracted Primary Care Physicians (PCPs), Specialists, and other Providers to ensure that our members receive medically necessary and appropriate covered services. We are a managed care delivery system in which the PCPs serve as a "gatekeeper" for member care. PCPs are responsible for coordinating and overseeing the delivery of services to members on their patient panel. We look forward to working with you and your staff to provide quality health care services to ONECare members.

MISSION STATEMENT

ONECare will be the most provider-oriented managed care organization that will strive to continuously improve the quality of services rendered to its members.

INTRODUCTION TO ONECARE

ONECare is an Arizona corporation which is contracted with the Department of Health and Human Services Centers for Medicare and Medicaid to provide health care services to Medicare beneficiaries. We are committed to working closely with our providers in order to deliver the highest quality services in a provider-friendly environment.

ONECare has a locally-based Chief Medical Officer (CMO) and senior management team. All health plan functions are conducted locally in our Phoenix office. All day-to-day operational decisions are made at the local health plan.

SECTION I: Introduction

ONECARE'S DEPARTMENTAL ORGANIZATION

PROVIDER NETWORK OPERATIONS

The Provider Network Operations Department is made up of provider services, contracting and data maintenance and is responsible for the contracting, maintenance and education of the provider network. Provider Network Operations serves as the liaison between providers and the health plan.

The Provider Network Representative is the provider's primary point of contact within ONECare. The Provider Network Representative will answer any questions you may have or direct you to the appropriate department within the organization. The Provider Network Representative is assigned to your office by geographic location and provider type.

MEMBER SERVICES

Member Services has primary responsibility for assigning members to PCPs and changing PCP assignments. The Member Services Department is the members' primary point of contact with ONECare. Member Services provides members with informational materials and educates members on use of the health plan. The majority of concerns, complaints, and grievances from members are logged through the Member Services Department.

MEDICAL/QUALITY MANAGEMENT

The Medical Management and Quality Management Departments include the functions of Medical Management, Quality Management, Behavioral Health and Prior Authorization. Detailed descriptions of these functions are found later in this manual. The ONECare CMO has oversight responsibility for all actions and decisions made within the Medical Management and Quality Management Departments. Medical Management includes prior authorization, concurrent review, case and disease management and medical claims review.

ONECare has a Credentialing/Peer Review Committee, Pharmacy and Therapeutics Committee, and Dental Network Oversight Committee which report to the Clinical and Service Quality Improvement/Medical Management Committee and ultimately to the Board of Directors.

CLAIMS

The Claims Department reviews and adjudicates submitted claims and reports all encounters to Center's for Medicare and Medicaid Services (CMS). In addition, Claims Customer Service has a "help line" to address any questions or concerns that providers may have about their submitted or paid claims.

CLAIM DISPUTES AND APPEALS

The Claim Disputes and Appeals Team is responsible for the timely adjudication of non-contracted provider claim disputes and member appeals.

COMPLIANCE

The Compliance Department oversees the ONECare Compliance Program which includes Health Insurance Portability and Accountability Act (HIPAA), Privacy, Fraud and Abuse, the Appeals process and the Cultural Competency Program.

PHARMACY

The Pharmacy Department is responsible for overseeing the consistent administration of the pharmacy benefit for ONECare members by ensuring appropriate and cost-effective pharmacy services.

FINANCE

Finance oversees the accounting and financial activities of the organization which includes processing payments for the provider network.