H0251 UnitedHealthcare Plan of the River Valley, Inc.
Dual Eligible (Dual Eligible Subset - Medicare Zero Cost-sharing) Special Needs Plan

Model of Care Score: 78.33%
2-Year Approval **January 1, 2015 – December 31, 2016**

Target Population

The UnitedHealthcare Plan of the River Valley, Inc. (United Healthcare) Dual Eligible Special Needs Plan (D-SNP) targets individuals who are dually-eligible for Medicare and Medicaid.

Based on data from UnitedHealthcare's total D-SNP population the average age of the membership is 63 years old and most members are female (64 percent). Half of the population is White (50 percent), one quarter of members are Black (25 percent) and 12 percent are Hispanic. Ninety-two percent of members have an annual income of less than $20,000.

D-SNP members often experience high service utilization rates due to multiple chronic conditions. The most prevalent diseases in this population are cardiovascular disease (31 percent), diabetes (26 percent), chronic obstructive pulmonary disease (14 percent) and heart failure (11 percent). About 67 percent of members suffer from multiple comorbidities.

Provider Network

UnitedHealthcare's network offers members a full spectrum of care to meet their unique needs. It includes primary care physicians (PCP); physicians specializing in gerontology, cardiology, endocrinology, nephrology, behavioral health, orthopedics, urology, rheumatology and ophthalmology; long-term care specialists and hospital "Centers of Excellence." The plan's ancillary network includes pharmacists, physical/occupational therapists, speech pathologists, radiology and laboratory specialists and dialysis centers.

UnitedHealthcare assigns each member to a health system navigator team that aligns with his or her individual needs and assigned risk group. The PCP plays a key role in the oversight of the member's care, treatment plan and goals.

Care Coordination and Management

Upon enrollment, the plan contacts the member by telephone or direct mail to administer a health risk assessment tool (HRA) that identifies his or her specialized needs and stratify the member accordingly. The HRA assesses the member's medical history, behavioral health conditions, psychosocial, functional and cognitive needs, medications and general health. The plan uses the results to identify members for targeted clinical programs. Members identified as high-risk must

complete a specialized, condition-specific comprehensive health assessment upon completion of the HRA. Reassessments occur at least annually for most members and semi-annually for high-risk members. If one of the following events occur acute admission, exacerbation of chronic condition, changes in health status/condition and/or changes in social supports or living situation, the plan performs a reassessment immediately.

Findings from the HRA and/or comprehensive health assessment help the health system navigator (HSN) or health navigator team (HNT), along with the PCP, member and other interdisciplinary care team (ICT) members generate an individualized care plan (ICP). Essential elements of the ICP include the member's needs, short and long-term goals, timelines for goal completion, outcome measures, healthcare preferences and specifically tailored services and interventions. The individuals mentioned above develop the ICP and send it to the member and other pertinent providers via mail, fax or the provider portal housed in the electronic record system. The ICT reviews and revises the ICP as it interacts with the member and updates it at a minimum, annually. It also updates the ICP as necessary with changes in the member's health status/condition or living situation.

Each member's ICT includes the PCP, the assigned HSN and the member and/or caregiver. Based on the member's expressed needs, preferences, clinical condition and/or living situation, the ICT expands to include appropriate professionals and community supports. The HSN serves as the facilitator and coordinator for the ICT and is responsible for providing oversight for the care management process, participating in the creation and maintenance of the ICP, ensuring that care is consistent with best practices, collaborating with other participants in efforts to improve care, outcomes and satisfaction and supporting and facilitating connections with local community care and service providers.

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.UHCCommunityPlan.com.