UnitedHealthcare Community Plan (Arizona Physicians IPA) H0321
Dual-Eligible (Full Duals) Special Needs Plan

Model of Care Score: 88.13%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

The target population includes individuals who are dually-eligible for Medicare and Medicaid that are enrolled in UnitedHealthcare Dual Special Needs Plan (D-SNP). Enrollment in the SNP product is voluntary and provides the membership with specialized services based on the population needs. UnitedHealthcare reviews overall membership composition through multiple avenues, including the Health Outcomes Survey (HOS) to determine member demographics, prevalence reports to identify top diagnoses and other data points and reporting to gather indicators such as socioeconomic status. UnitedHealthcare considers the following data points when considering membership composition: demographics, socioeconomic status, gender and prevalent diagnoses or diseases.

Provider Network

UnitedHealthcare Medicare network includes those providers and services important to the Special Needs population, including primary care physicians (PCP), long term care specialists, physicians specializing in internal medicine, family practice, gerontology, cardiology, endocrinology, nephrology, behavioral and mental health, orthopedics, urology, rheumatology, ophthalmology and hospital "Centers of Excellence." The ancillary network includes: pharmacists, physical/occupational therapists and speech pathologists, radiology and laboratory specialists and dialysis centers. Specialty physicians, therapists, health care providers and other social service or community-based providers are a part of the interdisciplinary care team (ICT) which coordinates member care, along with the member, primary care physician (PCP) and care manager.

Care Management and Coordination

The health risk assessment (HRA) assesses members care needs upon enrollment and annually thereafter. It focuses on medical conditions, medications, general health including home safety, help at home, hospital stays, memory loss and mental health. UnitedHealthcare uses the HRA to stratify members into low to moderate risk, high risk and advanced illness categories. Care managers use the HRA to assess member changes that may demonstrate an increased risk and transition them to a higher level of care management. The HRA and plan of care (POC) are housed in an electronic assessment and management system, from which clinical staff can review the HRA.

Lead program geriatricians, nurse practitioners, senior nurses and case managers use HRA responses to develop individualized POCs in order to identify health needs and ensure that

members are stratified and enrolled into the appropriate programs. Essential elements incorporated into the plan of care include the results of the HRA, preventative screening and service requirements based on age and gender, follow up strategies with PCP, goals of care, outcome measures for chronic condition management and services for members. The ICT updates the POC when it interacts with the member and when changes in care are required. The ICT and Case Managed assigned to care for the member have access to the POC in the secure electronic case management record.

The ICT includes the PCP and the member/caregiver at a minimum, and the PCP is responsible for enlisting additional ICT members as dictated by the member's needs. This includes nurse practitioners, physician assistants, RN case managers, case management associates, specialty physicians, pharmacists, nutritionists, therapists, mental and/or behavioral health experts, home care providers and other social service providers. The level of member interaction with the ICT varies based on stratification level with interaction ranging from member care coordination through the relationship with the PCP to frequent telephone outreach by the assigned case manager and home visits. As the member continues into more advanced case management, further expectations for engagement include weekly, bi-weekly and as needed meetings with an assigned case manager. The ICT meets in-person or over the telephone at a frequency determined by the member's risk level and program enrollment.

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 member needs.

For more information about this health plan refer to the Special Needs Plan's website at: https://www.uhcmedicaresolutions.com/