Upper Peninsula Health Plan, Inc., H2161
Dual Eligible (Dual Eligible Subset) Special Needs Plan

Model of Care Score: 85.00%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

The target population for Upper Peninsula Health Plan (UPHP) consists of dual-eligible members in the following Medicaid eligibility categories: Full Duals, Qualified Medicare Beneficiary (QMB) only, and QMB Plus. Its service area encompasses all 15 counties in the Upper Peninsula of Michigan, which the Federal Office of Rural Health Policy has designated as rural.

Provider Network

Many areas of the region are medically underserved and qualify as health-professional shortage areas. The plan's existing health care network dedicates constant resources to ensure that all residents receive high-quality health care.

UPHP is owned by fourteen (14) hospitals located across Michigan's Upper Peninsula that provide access to a full range of hospital, clinic, primary care, specialist and ancillary services. In addition, the plan's network includes a comprehensive network of mental health providers, home healthcare agencies, hospice, home infusion, and other specialized ancillary services. The network also includes contracted skilled nursing facilities (SNFs), many of which are associated with the UPHP hospital network, that are available to meet the needs of members.

To further support the unique needs of the population, UPHP collaborates with the Upper Peninsula Area Agency on Aging, (UPCAP), to provide home-based assessments, reassessments and care coordination services. As deemed necessary, UPCAP has a network of 70 home and community based supportive services providers and employs 25 experienced care managers. UPCAP also employs four additional staff members known as options counselors who are responsible for providing options and benefits counseling to individuals considering long-term care services.

Care Management and Coordination

UPHP conducts an initial risk assessment face-to-face in the member's home within 90 days of enrollment, which may include family or other informal support systems. Annual reassessment occurs within one year of the last assessment. These assessments can be conducted by a phone interview or face-to-face.

The assessment process consists of a comprehensive health risk assessment (HRA) that focuses on: social functioning, health conditions and preventive health measures, informal support services, nutritional and hydration status, dental and vision status, cognitive patterns, medications, communication and hearing, skin condition, mood and behavior patterns, functional status, disease, diagnosis and disabilities, an environmental assessment and service utilization.

The individualized care plan (ICP), developed for each member by a nurse care coordinator, documents the medical, psychosocial and functional interventions based on the health risk assessment. The care plan reflects coordination of services to improve care transitions across healthcare settings and providers, appropriate utilization and cost-effective service delivery. The interdisciplinary care team (ICT) is responsible for the outcomes of the care plan and apply the following objectives: reducing hospitalizations and SNF placements, improving self-management and independence, improving mobility and functional status, improving pain management, improving medication management or coordination of pharmacy services, improving quality of life and satisfaction with health status and health services. Care plans are adjusted based on the reassessment process and the member's increase or decrease in need for on-going services, as necessary.

The purpose of the ICT is to foster coordinated, structured, access to health and preventive health services. ICT members maintain records to document the care plan and substantial health and functional changes. The team encourages the member or caregiver/family member to participate in the development and revision of the care plan. The ICT may include any of the following: primary care physician or other treating board-certified physician, mid-level provider (e.g., nurse practitioner, physician's assistant), social worker, community resources specialist, RN (case manager), restorative health specialist (PT, OT, speech, recreation), behavioral or mental health specialist (psychiatrist, psychologist), dietitian, nutritionist, pharmacist, disease management coordinator, nurse educator, pastoral specialist and caregiver/family.

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: http://www.uphp.com/