H2161 Upper Peninsula Health Plan LLC
Dual Eligible (Dual Eligible Subset) Special Needs Plan

Model of Care Score: 90.00%
3-Year Approval **January 1, 2015 to December 31, 2017**

Target Population

The Upper Peninsula Health Plan Plus Dual Eligible SNP (UPHP) target population includes residents of the upper peninsula of Michigan who are Medicare managed care recipients, eligible for Medicaid and for whom the Michigan Department of Community Health (MDCH) has a responsibility for payment of cost sharing obligations under the State Plan.

The UPHP SNP population includes 411 members, who all speak English as their primary language. The majority of the SNP population is younger than 64 and 42 percent are 65 or older. Females comprise 60 percent of the membership. Hypertension, depression and arthritis are the top three chronic conditions, 14 percent of members report using tobacco products and 2 percent have cognitive disorders, such as a traumatic brain injury, Alzheimer's or memory loss. Just over half of members live in a house or trailer, about one third live in an apartment and the remaining live in a skilled nursing facility (SNF), adult foster care home or an assisted living facility.

Provider Network

UPHP has a comprehensive network of providers that deliver all Medicare required home and community based services. UPHP is owned by 14 hospitals across the upper peninsula of Michigan that provide a full range of hospital, clinic, primary care, specialist and ancillary services. The UPHP HMO network also has over 800 licensed physicians, facilities and/or services including: acute inpatient hospitals, inpatient psychiatric facility services, outpatient hospital services, surgical services, dialysis services, therapies (physical, occupational, speech), laboratory services, SNFs, family practice/primary care physicians (PCP), specialty physicians, cardiologists, endocrinologists, general surgeons, infectious disease specialists, nephrologists, neurologists, oncologists, palliative care, psychiatry, home health agencies and durable medical equipment (DME) providers. The UPHP network also includes mental health providers, Medicare-certified home healthcare agencies, hospice, home infusion and other specialized ancillary services.

Care Management and Coordination

Through oversight of the director of quality management and daily oversight of the clinical coordinator-care managers (CM) each new member receives a health risk assessment (HRA)

within 90 days of enrollment. The HRA is completed in collaboration with the Upper Peninsula's Area Agency on Aging. Whenever possible, the HRA is performed in the member's home. At a minimum, the CM must be a registered nurse (RN) or have a Bachelors of Social Work degree to meet members' medical and long term support needs. The CM directs member care through the development and implementation of the individualized care plan (ICP) and coordination of the interdisciplinary care team (ICT).

The ICP is a person-centered planning process, based on HRA data and the self-management goals determined by the member. The initial ICP is completed within 90 days of enrollment and updated within 30 days of a change in health status. The ICP is documented in the UPHP care management database by the CM.

The CM is responsible for the ICT composition and facilitating ICT conferences for each member. The medical, functional, cognitive, psychosocial and mental health information is the foundation for the development of interventions by the ICT to assist members in the achievement of their ICP self-management goals. Membership of each ICT varies and may include any of the following: CM clinical coordinator, social worker, PCP, member, caregiver/family/designated support person, specialist provider, long term services and supports (LTSS) coordinator and a behavioral health support coordinator.

The ICT assists the member in the development and achievement of the goals of the ICP and applies the following objectives: reducing SNF placements and hospitalizations, improving self-management and independence, improving mobility and functional status, improving pain management, improving medication management or coordination of pharmacy services and improving quality of life an satisfaction with health status and health services.

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.uphp.com/medicare.