H3379 UnitedHealthcare of New York, Inc.,
Institutional (Institutional – Facility) Special Needs Plan

Model of Care Score: 95.63%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

UnitedHealthcare of New York, Inc. (UnitedHealthcare) target population includes institutionalized individuals that reside in nursing homes located in the designated service areas in New York. Enrollment in this I-SNP product is voluntary and provides specialized services based on the population needs. United Healthcare considers the following data points of membership composition: age, ethnicity, Medicaid status, income status in addition to difficulty/inability to walk, inability to see and difficulty reading.

Across all UnitedHealthcare I-SNPs, the prevalence rate for the top five health diagnosis reveals: renal failure (82.96 percent), vascular disease (73.07 percent), congestive heart failure (58.80 percent), diabetes with renal or peripheral circulatory manifestation (47.59 percent) and major depressive, bipolar and paranoid disorders (46.06 percent).

Provider Network

United Healthcare Medicare network includes those providers and services important to the I-SNP 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 hospitals. The ancillary network includes: pharmacists, physical/occupational therapists and speech pathologists, radiology and laboratory specialists and dialysis centers.

Each month, United Healthcare conducts a review by local market to evaluate if the provider network encompasses sufficient specialty types to address the most prevalent health care needs of the special needs membership. On a semi-annual basis, the plan conducts a comprehensive analysis to review geographic and numeric availability of all providers including specialties and ancillary providers. This review includes cultural and linguistic needs of the membership as it compares to the network composition.

Care Management and Coordination

Within 30 days of enrollment, the nurse practitioner (NP) or physician assistant (PA) conducts a face-to-face health risk assessment (HRA) to identify the beneficiary's health risk and key areas

on which to focus in the individualized care plan (ICP) to reduce or minimize adverse impact to the beneficiary resulting from the health risk. The HRA includes, but is not limited to: beneficiary's health status, condition specific assessment, clinical indicators, activities of daily living, medication review, mental health and cognitive assessment, advanced care planning discussion and care level assignment. The NP/PA documents the assessment in the member's electronic medical record. Every quarter, the NP/PA assesses the member for changes in health risk status from the previous assessment and updates the ICP with the interdisciplinary care team (ICP).

With the HRA responses as a baseline, the PCP and NP/PA, with member/caregiver input develops the ICP and identifies the interventions needed to address the member's health care conditions. The NP/PA reviews the ICP with the PCP and updates it at least monthly to reflect any changing conditions, change in treatment plan and wishes or preferences of the member. As other members of the ICT become involved, the ICP is reviewed and updated. Additional assessments are conducted with changes in condition, care transitions from acute care to specialized nursing facilities, quarterly for quality data collection/analysis as well as annually.

Every member has access to an ICT led by the PCP which includes, at a minimum the PCP, the member/caregivers and the assigned NP/PA. The PCP provides clinical management while the NP/PA oversees other services and coordinate benefits. As the member is enrolled in various clinical programs, participation in the ICT expands to include other care team members to meet his/her needs, including, but not limited to: social workers, pharmacists, physical, occupational and speech therapists, and mental and/or behavioral health experts. Interactions between members and the ICT as well as the frequency of ICT meetings is dependent on the member's risk level and clinical program enrollment. Documentation of ICT activities, including the ICP, occur in the individual member's case management record.

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: http://www.uhc.com/