UPMC for You, Inc., H4279
Dual Eligible (Medicare Zero Cost Sharing) Special Needs Plan

Model of Care Score: 90.63%
3-Year Approval **January 1, 2013 – December 31, 2015**

Target Population

In January 2012, UPMC Health Plan began to offer a zero cost share full dual eligible SNP (serves beneficiaries with both Medicare and full Medicaid coverage) known as UPMC *for You* Advantage. More than 57% of the target population is under age 65 and females comprise nearly 64% of the membership. Almost half of the membership resides in urban Allegheny County and over 24% have serious mental illness. The five most common conditions in the population are: hypertension, hyperlipidemia, diabetes, osteoarthritis and COPD. In addition, the top five DRGs include: psychosis, COPD with major and minor complications, cellulitis and rehabilitation with complications.

Provider Network

UPMC *for You* Advantage maintains contracts with credentialed providers to ensure that members have access to high quality care. Providers assess, diagnose, and treat members in collaboration with the interdisciplinary care team (ICT) and provide 24-hour access to a clinical consultant. At a member level, providers assist with the development and update of the individualized care plan (ICP) and participate in conference calls for interdisciplinary case reviews as needed. They also assist the health plan in the development, implementation, and evaluation of disease management programs.

Participating providers include: acute care hospitals and medical centers offering in-patient care services; hospital-based emergency departments and urgent care centers; skilled nursing facilities; rehabilitation centers and rehabilitation or restorative therapy specialists; long term care centers; home care agencies offering home health services (clinical assessments and treatment, wound management, home safety assessments, and home-based end-of-life care); durable medical equipment providers; pharmacies and clinical pharmacists; outpatient centers including dialysis facilities; radiology and diagnostic facilities; ancillary providers, primary care practitioners (PCPs), mid-level practitioners; behavioral health specialists and medical specialists pertinent to targeted chronic conditions including oral health. The SNP also offers telemonitoring and telemedicine services for unique patient populations through a few of the larger hospitals within the network.

Care Management and Coordination

Understanding members' health risks of requires the plan to obtain information from multiple sources. UPMC *for You* Advantage uses data obtained from: internally developed health assessment surveys (HAS) completed by members; any applicable claims data; and any information obtained through conversations with members, their caregiver(s), and the providers

who care for them. A HAS is sent within 10 days of a member's enrollment in the UPMC *for You* Advantage. New members that do not return the mailed HAS survey are contacted by automated telephone messaging. The SNP also performs a HAS on every member on an annual basis.

The ICT uses this comprehensive set of data to develop an ICP for the member based on the member's physical and behavioral health status, lifestyle risks, types of services needed or receiving, where services are provided, level of understanding of diseases and management of those conditions, support from caregiver(s), and social needs. It creates a care plan with the member's input that is structured to help the member monitor their progress. All interventions are aimed at increasing the member's knowledge of their condition and improving their ability to manage it.

At the core of the ICT is the member's PCP (including mid-level providers such as nurse practitioners or physician assistants) who coordinates the care of their patients. Core team members include: member and caregivers/family, health coaches (nurse and social worker care managers), patient based care manager (PBCM) located in patient centered medical home (PCMH) sites, behavioral health nurse coaches and lifestyle health coach. The plan adds other providers as needed; the composition of the ICT is based on a review of the demographics of the membership, prevalence of chronic diseases or conditions, other clinical and financial reports and its experience managing the population.

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: www.upmchealthplan.com/snp