H4514 UnitedHealthcare Community Plan of Texas, LLC
Institutional (Institutional Facility) Special Needs Plan

Model of Care Score: 80.00%
2-Year Approval **January 1, 2015 – December 31, 2016**

Target Population

The UnitedHealthcare Community Plan of Texas, LLC (UnitedHealthcare) Institutional Special Needs Plan (I-SNP) targets individuals who reside continuously or are expected to reside continuously in a long-term care facility for 90 days or more. Long-term care facilities consist of nursing facilities, an intermediate care facility for the mentally retarded or an inpatient psychiatric facility.

Based on data from UnitedHealthcare's total I-SNP population, the average age of the population is 69 years old and 72.3 percent are female. The majority of the membership is White (75.8 percent); Black and Hispanic members comprise 18.1 percent and 2.6 percent respectively. Members largely speak English (99.2 percent) and Spanish (0.42 percent).

Prevalence rates for the top five diagnoses within the population include: vascular disease (70.06 percent), major depressive, bipolar, and paranoid disorders (43.16 percent), congestive heart failure (40.72 percent), diabetes with chronic complications (31.81 percent) and chronic obstructive pulmonary disease (28.74 percent).

Provider Network

UnitedHealthcare's network offers members a full spectrum of care to meet their unique needs. It includes primary care physicians (PCPs); physicians specializing in internal medicine, family practice, gerontology, cardiology, endocrinology, nephrology, behavioral and mental health, orthopedics, urology, rheumatology and ophthalmology; long-term care specialists; and hospital "Centers of Excellence."

The plan's ancillary network includes: pharmacists, physical/occupational therapists, speech pathologists, radiology and laboratory specialists and dialysis centers. In addition, members have access to skilled nursing facilities, durable medical equipment and other ancillary providers in each area.

Upon enrollment, the plan assigns a nurse practitioner or physician assistant (NP/PA) to each member who is responsible for assessing the member's needs, providing appropriate, timely services and maintaining the individual's optimum level of health. Additionally, the PCP plays a key role in the oversight of the member's care, treatment plans and goals.

Care Coordination and Management

Within 30 days of enrollment, the NP/PA performs a face-to-face, comprehensive initial health risk assessment (HRA) to determine a member's health status. The HRA assesses the member's chronic conditions, medications, general health, utilization, mental health, need for services and/or psychosocial needs. The plan also uses the HRA to screen members for enrollment into specific clinical programs and stratify the member for risk to best meet his or her needs. The NP/PA completes the HRA as part of the initial medical history and physical assessment and later as part of a quarterly review. When there is a change in the member's health status or after a hospitalization, the NP/PA conducts an additional assessment.

The PCP and NP/PA develop an individualized care plan (ICP) with the member and/or caregiver to identify agreed upon interventions based on their wishes and preferences along with the knowledge of the member's conditions. The ICP contains interventions to: support the member's maximum level of functioning, promote quality of life and meet established goals, noting the risks and benefits of each one. The NP/PA reviews the ICP with the member and/or caregiver and the PCP and updates it at least monthly to reflect any changes in condition, changes in the treatment plan or changes in the wishes or preferences of the individual. Other members of the interdisciplinary care team (ICT) review and update the ICP as they become involved with the member's care. The ICT also reviews the ICP during monthly case rounds, quarterly case conferences or anytime the individual's condition warrants it.

Every member has access to an ICT led by the PCP that includes at a minimum, the member and/or caregiver(s) and the NP/PA. As the member enrolls in various clinical programs, ICT participation expands to include other team members to meet his or her needs. These team members can consist of: a registered nurse case manager, a case management associate, specialty physicians, pharmacists, nutritionists, therapists, mental and/or behavioral health experts, home care providers and other social service providers.

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.UHCMedicareSolutions.com