H5652 UnitedHealthcare Insurance Company,
Chronic or Disabling Condition (Chronic Heart Failure) Special Needs Plan

Model of Care Score: 76.67%
1-Year Approval[1] **January 1, 2015 to December 31, 2015**

Target Population

Erickson Advantage (Erickson) enrolls eligible continuing care retirement community (CCRC) residents in UnitedHealthcare's Chronic Condition Special Needs Plan (C-SNP). Members must have one of the following confirmed diagnosis(es) to enroll: congestive heart failure, diabetes mellitus or cardiovascular disease. Based on data from Erikson's total C-SNP population the average age of members is 85 years old, and 99 percent of members are White and speak English as their primary language. There are twice as many female members compared to male members. All members have at least one of the qualifying diagnoses, however most have multiple comorbidities which increase the impact of disease, cognition and function. On average the C-SNP serves a middle class cross-section of the country, who are educated, had professional careers or trades or were housewives. Most members have supportive family involvement either in person or from a distance. Two thirds of members have vascular disease, 32 percent have diabetes, 32 percent have cardiac arrhythmias and 19 percent have congestive heart failure (CHF). All members reside within the gated CCRC. The CCRC services are all designed around the specific needs and potential barriers of the residents' demographics.

Provider Network

Erickson contracts with board certified specialty providers, who are contracted and credentialed by UnitedHealthcare. Erickson communities offer full-time on campus primary care medical centers which includes primary care providers (PCP), podiatrists, mental health practitioners and preferred specialty providers. Core specialty providers include but are not limited to cardiology, endocrinology, urology, orthopedics and ophthalmology. These specialties provide a geriatric focus of care. Erickson also contracts with outpatient facilities and tertiary facilities including centers of excellence and laboratory and basic radiology services. Erickson's network has approximately 2,300 cardiologists and 500 endocrinologists. Members are referred to hospitals with specialized expertise in complex cardiovascular procedures via a transportation benefit to specialty provider offices. The CCRC provides skilled nursing and long term care facilities on campus, which includes nurse practitioners, registered nurses, rehabilitation therapists, social work and mental health specialists.

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[1] Per CMS, all plans that undergo the Cure process are limited to a one year approval, regardless of the final score.

Care Management and Coordination

At enrollment, all members receive a comprehensive health risk assessment (HRA) and those members who are continuously enrolled receive an annual HRA at the beginning of each calendar year. If there is a change in health status before the next scheduled HRA, the member is monitored through hospitalization reports, security first responder incident reports (can include assistance with falls, confusion, urgent medical needs, etc.) and care transition reports.

Members receive a customized, individualized care plan (ICP) based on their HRA responses. Those members enrolled in complex case management or disease management programs, are high risk members who benefit from more intensive one-on-one support by a care coordinator (CC), in conjunction with the interdisciplinary care team (ICT). All complex case management and disease management cases include a documented comprehensive initial assessment and an ICP. The ICP is developed based on the results of a comprehensive, multiple domain in home assessment conducted by the CC, from data retrieved by electronic medical record review, the member and/or family interviews and other relevant resources.

The composition of the core ICT includes the PCP, the community social worker, health plan nurse CC and the member and caregiver. Additional ICT staff are included based on the member's needs, for example a rehabilitation specialist. HRA results are also used to determine if additional membership is needed in the ICT.

The ICP includes member specific problems, goals, along with goal status and interventions. Updates are made as the ICT becomes aware of changes that impact the current care plan. In the event a goal is not met, the ICT reevaluates the ICP and interventions. The CC documents member specific issues addressed in ICT meetings in the member's health plan care management software. The CC attends community care transition meetings when a member is involved, and does onsite discharge planning, teaching and clinical reviews for members in skilled nursing facilities.

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.ericksonadvantage.com