United HeathCare (Care Improvement Plus, R9896)
Dual Eligible Subset (Medicare Zero Cost-sharing) Special Needs Plan

Model of Care Score: 93%
3-Year Approval **January 1, 2014 – December 31, 2016**

Target Population

The target population includes individuals who are dually-eligible for Medicare and Medicaid that are enrolled in UnitedHealthcare Dual Special Needs Plan (DSNP). Enrollment in the SNP product is voluntary and provides the membership specialized services based on the population needs. Overall membership composition is reviewed and addressed through multiple avenues, including the Health Outcomes Survey (HOS) to determine member demographics, quarterly prevalence reports to identify top diagnoses and other data points and reporting to gather indicators such as socioeconomic status. 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.

Provider Network

UnitedHealthcare Medicare network includes those providers and services important to the Special Needs 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 hospital "Centers of Excellence." The ancillary network includes: pharmacists, physical/occupational therapists and speech pathologists, radiology and laboratory specialists and dialysis centers. United Behavioral Health (UBH) provides the mental health practitioner network for the special needs population.

Care Management and Coordination

The health risk assessment (HRA) is a tool used with new members upon enrollment and annually thereafter to stratify them according to their care needs. The plan contacts the member by telephone or direct mail after enrollment. The HRA focuses on medical conditions, medications, general health including home safety, help at home, hospital stays, memory loss and mental health. The registered nurse case manager (RNCM), case manager (CM)/service coordinator (SC), health services director (HSD), and manager of case managers (MCM) review and analyze the HRA to stratify members. The plan's care management system is a structured electronic assessment and management application which supports the case managers, NPs, PAs and others in capturing member-centered assessments and information and all care management activities and documentation.
The initial plan of care (POC) is based on the HRA responses. Lead program geriatricians, nurse practitioners, senior nurses and case managers analyze it annually to ensure health needs are identified and that members are stratified and enrolled into the appropriate programs. The high

risk care managers (HRCMs) have an integral role in managing the POC from start to finish and also communicate and distribute the POC to all members of the interdisciplinary care team (ICT). The plan of care includes the results of the HRA, preventive screening and service requirements based on age and gender, follow-up strategies with the PCP, goals of care and outcome measures for chronic condition management, services for those with functional limitations, those needing caregiver support and community services for those who are frail or at end of life. The ICT shares POC updates with the member and caregiver verbally, when feasible.

Every member has access to an ICT led by the PCP which includes at a minimum the PCP, the member and/or their caregivers. As the member is enrolled in various clinical programs, participation in the ICT expands to include other care team members to meet the his/her needs, including, but not limited to: nurse practitioners, physician assistants, RN case managers, case management associates, specialty physicians, pharmacists, nutritionists, therapists, mental and/or behavioral health experts, home care providers and other social service providers. UnitedHealthcare encourages member and caregiver participation in the ICT. Interactions between members and the ICT depend on the member's level of need, engagement through outreach and education including educational reminders, HRA, reassessment of needs, telephone access to a nurse, screening exams, immunizations and wellness programs.

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: https://www.uhcmedicaresolutions.com/