

**UCare Minnesota, H2456
Dual Eligible (Medicare Zero Cost-Sharing) Special Needs Plan**

Model of Care Score: 90.00%
3-Year Approval

January 1, 2012 – December 31, 2014

Target Population

UCare serves more than 9,000 special needs individuals that are full-benefit, dual-eligible frail elderly age 65+ residing at home in community facilities such as customized living or in nursing homes.

Provider Network

UCare's provider network for all products includes more than 6,800 primary care physicians (PCP), 15,000 specialists, 7,800 primary and specialty clinics, and 900 dental providers as well as a wide array of durable medical equipment (DME) suppliers. The network includes: hospitals, outpatient centers, lab and X-ray services, pharmacies, home health agencies, therapy services, mental and behavioral health providers, substance abuse services, and nursing homes. UCare reviews requests for needed services or treatments from non-contracted providers if the network is determined to be insufficient to fully meet the special needs of the population. When services needed by a member cannot be obtained from network providers, such care is covered at the preferred benefit level. The member is not adversely affected.

Care Management and Coordination

UCare offers a face-to-face health risk assessment (HRA) for each member within 30 days of enrollment. This approach identifies risks members may be experiencing, prioritizes care needs, and facilitates interventions that can prevent or minimize health problems or complications. The information gathered through the HRA is used to identify gaps in medical, behavioral, and psychosocial services, and to identify social supports to assist members in maintaining independence at the highest possible level.

Along with the comprehensive health assessment, the care coordinator develops an individualized comprehensive care plan (ICP) that addresses the member's: functional status, medical history, psychosocial history, social service goals, strengths and service utilization. The ICP contains the results of the HRA, member-driven goals and objectives, specific services and benefits, member preferences for care, management of risk, and outcomes of goals. A copy of the ICP is given to the member and/or responsible party and a member signature is obtained. The care coordinator sends a copy or summary of the ICP to the PCP on an annual basis.

The information contained in the comprehensive ICP is used to monitor gaps in medical, behavioral and psychosocial services. The focus for the member is on preventive and maintenance health care services, disease-specific interventions, and increased coordination between social service and health care providers. Care coordinators provide on-going monitoring of each member consisting of a check-in at least every six months, via phone or face-to-face.

Members are offered a comprehensive face-to-face reassessment at least annually, and more often as warranted by a change in the member's condition.

UCare defines the interdisciplinary care team (ICT) as a team of people who are involved with the member to coordinate and provide health care services. Primary members of the ICT include the care coordinator, the member and/or member's family/authorized representative, and the PCP. ICT members may also include any and all other health and service providers who are involved in the member's care, such as specialty care providers, social workers, mental health providers, nursing facility staff, and others.

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: <https://www.ucare.org/HealthPlans/Medicare/MSHO/Pages/default.aspx>