UCare Model of Care

Minnesota Health Options (MSHO) & UCare Connect + Medicare

2019
UCare’s Model of Care (MOC)

Overall goal of the MOC:

- Drive improvements in health outcomes and quality of life for members.

UCare’s MOC is designed to:

- Increase access to affordable, cost-effective health care.
- Improve coordination of care.
- Ensure seamless transitions of care.
- Manage costs.
UCare Special Needs Plans (SNP)

Minnesota Senior Health Options (MSHO):
- The MSHO program serves elderly members who are dually eligible for Medicare and Medical Assistance and are 65 years or older.

Special Needs Basic Care (UCare Connect + Medicare):
- The UCare Connect + Medicare Program serves members with disabilities who are dually eligible for Medicare and Medical Assistance under the age of 65.
UCare Special Needs Plans

Integrated products combining Medicaid & Medicare:

- Parts A, B, and D (pharmacy)
- Members have 1 ID card
- One phone number to call for health plan questions

Over 15,000 members:

- 13,000 MSHO
- 2,400 UCare Connect + Medicare
Why does UCare have a MOC?

**Required by CMS & DHS & has four components:**
- Population description & characteristics
- Care Coordination details
- Provider Network to ensure adequate access
- Quality Measures & Process Improvement goals

**It helps provide:**
- Appropriate access to primary & specialty care providers
- Integrates care coordination based upon a member’s Health Risk Assessment
- Ensures members receive individualized care plans
- Encourages and provides care transitions support to members and families
Care Coordination

The care coordinator (CC) coordinates care and services for the member which includes:

- Face-to-face Health Risk Assessment (HRA) annually which is used to evaluate members’ health risks, gaps in care and quality of life.
- An individualized, person centered care plan.
- Facilitating access to affordable care such as: medical, preventive, mental health and social services.
- Communicating with the Interdisciplinary Care Team (ICT), a team of professionals involved with the member to coordinate and provide health care services.

Care Coordinators are Qualified Professionals:

- Registered Nurses, Nurse Practitioners and Social Workers
Care Transition Protocols

- The care coordinator assists members, families, facilities, providers, or others with planned and unplanned transitions from one care setting to another.
  - Examples include: Transition from hospital to home or nursing facility

- Goal is improved transitions to reduce fragmented care and avoid re-hospitalizations.
Provider Network

UCare’s provider network meets a wide range of needs.

- The network includes, but is not limited to:
  - Primary care providers
  - Specialists
  - Primary and specialty clinics
  - Dental providers

- The member may have care from any contracted provider without referral.

- Model of Care training is offered annually to all providers, delegates and UCare employees.
Clinical Practice Guidelines (CPGs)

- UCare adopts clinical practice guidelines to support good decision-making by patients and clinicians to improve health care outcomes, and meet state and federal regulatory requirements.

- CPGs are available on our provider website.
Quality Measurement & Performance Management

UCare collects and analyzes data and reports from a variety of sources to:

- Annually evaluate the Model of Care.
- Identify improvements to be made for our members.
Summary

- Care Coordination is one component of our care model.
- UCare has two products with care coordination services – MSHO & Connect + Medicare which currently serves around 15,000 members.
- Care coordinators work with members, families and providers on transitions of care with a goal of reducing re-admissions.
- UCare uses data and reports to evaluate the Model of Care annually.