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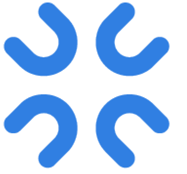
UCare Model of Care

Minnesota Senior Health Options (MSHO) & UCare Connect + Medicare



Training Purpose

To provide information about the Model of Care requirements for UCare Dual Special Needs Plans MSHO and UCare Connect + Medicare, as required by the Centers for Medicare and Medicaid Services (CMS)

To outline the importance of your role as a provider or care coordinator of the MSHO and Connect + Medicare interdisciplinary care team

Explain how you may interface with the care coordination team in the provision of care

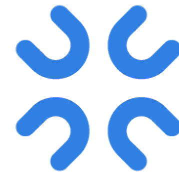
UCare’s Model of Care (MOC)

Overall goal of the MOC:

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

UCare’s MOC is designed to:

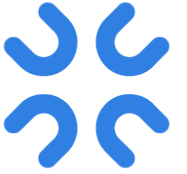
- Increase access to affordable, cost-effective health care
- Improve coordination of care
- Ensure seamless transitions of care
- Manage costs



UCare’s Special Needs Plans (SNP)

Minnesota Senior Health Options (MSHO):	Special Needs Basic Care (UCare Connect + Medicare):	To be eligible, members must:
• The MSHO program serves elderly members who are dually eligible for Medicare and Medical Assistance and are 65 years or older who reside within UCare’s service area	• The UCare Connect + Medicare Program serves members with disabilities who are dually eligible for Medicare and Medical Assistance between the ages of 18-64 who reside within UCare’s service area	• Be Medicare and Medicaid eligible • Have Medicare Part A and B • Meet the age requirements per product

UCare’s Special Needs Plans



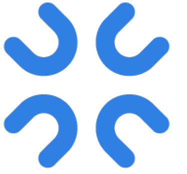
Integrated products combining Medicaid & Medicare:

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

Over 17,000 members:

- 13,400 MSHO
- 3,530 UCare Connect + Medicare

Member Demographics



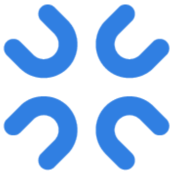
MSHO

- Average Age:76 years
- Age range: 65-110 years
- 66% Female/ 34% Male
- Living arrangements:
  - 36% community
  - 16 % institutional
  - 48% waiver

UCare Connect + Medicare

- Average Age: 48 years
- Age range: 19-65
- 55% Female/ 46% Male
- Living arrangements:
  - 98% community
  - 2% institutional

Why does UCare have a MOC?



Required by CMS & DHS & has four components:

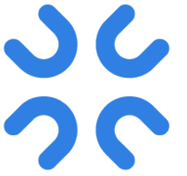
- Population description & characteristics
- Care coordination details
- Provider Network to ensure adequate access
- Quality Measures & Process Improvement goals

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

How do Members enroll in MSHO or Connect + Medicare

- Enrollment is voluntary
  - Ways to enroll:
    - ✓ Member's county financial worker
    - ✓ UCare's Enrollment: 612-676-3554 or 800-707-1711
    - ✓ Senior Linkage Line: 800-333-2433 (for MSHO)



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 Coordinator’s Role

- Every MSHO member is assigned a care coordinator
- Connect + Medicare members are assigned a care coordinator based upon their assessed need
    - The care coordinator partners with the member and their Interdisciplinary Care Team
        - All Primary Care Physicians are considered an integral part of the member’s interdisciplinary care team
    - The care coordinator is the primary point of contact ensuring ongoing communication between members of the Interdisciplinary Care Team
- To find out who the care coordinator is for a member, call UCare’s Customer Service:
    - MSHO: 612-676-6868 or 866-280-7202
    - Connect + Medicare: 612-676-6830 or 855-260-9707

Interdisciplinary Team

- The Interdisciplinary Team consists of:
  - Member and/or appropriate family/caregiver
  - MSHO or Connect + Medicare care coordinator
  - Primary Care Provider
  - Other providers appropriate to specific health needs (Specialists, Mental Health Providers, Palliative Care Team, Pharmacist, etc.)
  - Others included as identified by the member and others on the team

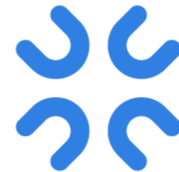
Home and Community Based Services

MSHO members may qualify for Home and Community Based Services (HCBS)

HCBS allow flexibility and creative alternatives for members to remain their homes/community vs. a nursing facility

Some of the services funded through HCBS are:

- Skilled Nurse Visits (SNV)
- Home Health Aids (HHA)
- Personal Care Assistant (PCA)
- Homemaking
- Adult Day Centers



Care Transition Protocols

1

Care coordinators 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

2

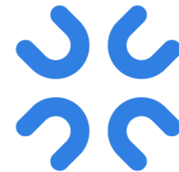
Care coordinators follow up with the member to:

- Discuss their health status changes and discharge instructions
- Ensure that follow up appointments have been scheduled
- Ensure member understands any changes in their medications

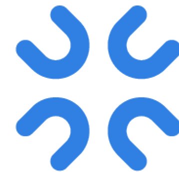
3

Overall goal is to improve 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



Quality Measurement & Performance Management

UCare collects and analyzes data and reports from a variety of sources to measure plan performance which include:

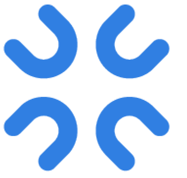
Claims, utilization, pharmacy, demographic information

HEDIS, CAHPS, Stars, predictive modeling, and evidence based analytic tools

This information helps UCare to:

Annually evaluate the Model of Care

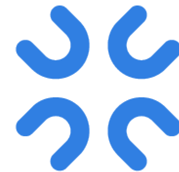
Identify improvements to be made for our members



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 UCare’s provider website



Summary

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- Care coordination is one component of UCare's care model
- The UCare Model of Care applies to MSHO & Connect + Medicare which currently serves around 17,000 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.
- Providers play an important role as a member of the Interdisciplinary Care Team

In Closing

Maintain

Please maintain a record of completion of this Model of Care Training.

Reach out

If you have any questions, please reach out to the UCare Clinical Liaisons at:

- Phone: 612-294-5045
- Email: clinicalliaison@ucare.org