UCare Model of Care
Minnesota Senior Health Options (MSHO)
&
UCare Connect + Medicare
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 Basis 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 & D (pharmacy)
  - Members have one ID card
  - One phone number to call for health plan questions

- Over 11,000 members currently enrolled
  - 10,000 with MSHO
  - 1,000 with 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 on a member’s Health Risk Assessment
  - Ensures members receive individualized care plans
  - Encourages and provides care transition support to members & 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.
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 & UCare Connect + Medicare which currently serves around 11,000 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.
UCare Contacts

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