

MEMBER PROFILE:

UCare

UCare, an independent, non-profit health plan, was established in 1984 by the Department of Family Practice and Community Health at the University of Minnesota Medical School. While UCare does not employ any of the providers that serve its members, its primary care roots are still evident. Members are encouraged to align with a primary care practice that can serve as a base for care coordination activities that are vital to members with complex care needs. UCare provides health coverage and services to more than 400,000 members in Minnesota and western Wisconsin, nearly 10,000 of whom are over age 65 and dually eligible for Medicare and Medicaid.

Medicare-Medicaid Integration Status

Minnesota's Senior Health Options (MSHO) program was founded in 1997 through a grant from the Robert Wood Johnson Foundation to pilot new models of integration for Medicare-Medicaid enrollees. UCare was among the first plans to participate in MSHO – what is now one of the most well-regarded models of integrated care in the country. Through MSHO, UCare operates a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP) that coordinates long-term services and supports and provides supplemental benefits, such as dental and fitness to a diverse group of almost 10,000 members aged 65 years and older. UCare is also actively engaged in Minnesota's efforts to align administrative functions to improve Medicare-Medicaid beneficiaries' experience in the MSHO program through a demonstration partnership with the Centers for Medicare & Medicaid Services.

Key to Success: Locally-Based Care Coordination

One of UCare's founding principles is that care coordination should be kept at the local level whenever possible. The plan uses two different models of care coordination: (1) directly employing approximately 25 care coordinators; and (2) contracting with care systems, county agencies, and independent organizations that employ their own care coordinators. With this arrangement, the plan is able to provide services across wide geographic and sometimes rural areas, contracting with more than 200 care coordinators across the state of Minnesota. The plan encourages care coordinator-physician communication. In some cases, care coordinators are employed by primary care practices or care systems, so interactions with physicians are seamless. When care coordinators are employed by counties or independent organizations, they are responsible for communicating with UCare members' primary care practices.

The plan has developed several innovative provider payment models that create incentives to improve care for Medicare-Medicaid enrollees and reduce hospital stays and emergency department visits. For example, UCare worked with a health system in rural north central Minnesota to create a patient-centered accountable care organization model that stresses a central primary care focus, coordinated care, and specialized care. The care management payment and risk/gain share arrangement was designed to serve Medicare, Medicaid, and dually eligible members in this rural region. This model successfully reduced inpatient admissions by 18 percent and average medication costs per enrollee by 38 percent.¹

QUICK FACTS

- **Organization type:** Managed care organization
- **Tax status:** Non-profit
- **Year founded:** 1984
- **Integration model:** FIDE-SNP
- **FIDE-SNP enrollment:** 10,000 Medicare-Medicaid enrollees
- **Service area:** 57 of 87 counties in Minnesota

PRIDE Contact

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The [Promoting Integrated Care for Dual Eligibles \(PRIDE\)](#) initiative, made possible by The Commonwealth Fund, is a consortium of high-performing health care organizations focused on improving the care of individuals dually eligible for Medicare and Medicaid. The Center for Health Care Strategies (CHCS) is helping PRIDE members to identify and test innovative strategies that enhance and integrate care for Medicare-Medicaid enrollees. CHCS is a nonprofit health policy resource center dedicated to advancing access, quality, and cost-effectiveness in publicly financed health care. For more information, visit www.chcs.org.

INTEGRATED CARE IN ACTION

Locally-based care coordination was the key to helping an 88-year-old member of UCare's MSHO plan to avoid moving to a nursing facility. A long list of health challenges including bipolar disorder, severe depression, hypertension, diabetes, and knee and back pain left the member unable to dress, groom, or bathe himself independently. These functional restrictions qualified him for a nursing facility level of care. He had multiple hospitalizations and short-term stays in rehabilitation, and was failing in an independent living environment even with the supports and services that were in place.

Despite his difficulties, the member did not want to be in a nursing facility, so his locally based UCare care coordinator helped him to find an assisted living facility that could meet his needs. He has now lived in this facility for two years and receives support from the staff to manage all of his care including his prescriptions and mental health counseling. Since the care coordinator from UCare assisted him with the move, the member has not had any hospitalizations or major health changes and has been able to avoid nursing home placement.

¹ Alliance of Community Health Plans (ACHP). *Health Plan Innovations in Patient Centered Care*. March 2013. <http://www.achp.org/wp-content/uploads/downloads/2013/03/Strengthening-Primary-Care-for-Patients-ACHP-20132.pdf>.