Strengthening Primary Care for Patients:

UCare | Minneapolis, Minn.

Background

UCare is an independent, nonprofit health plan with 300,000 members residing throughout Minnesota and western Wisconsin. It was started by the Department of Family Practice and Community Health at the University of Minnesota, and has had a focus on support for primary care from its inception. UCare provides health insurance coverage exclusively to individuals who are eligible for state and federally funded coverage, such as Medicare, Medicaid and Medicare/Medicaid dually eligible patients.

The health plan became involved in the Lakewood Health System patient-centered medical home (PCMH) and other PCMH pilots primarily because of a statewide push toward patient-centered models of care. In 2008, as part of a health care reform package passed in Minnesota, state legislators created guidelines for primary care practices to achieve health care home status and appointed oversight for certification to the Minnesota Department of Health. Beginning in July 2010, Minnesota health insurance plans like UCare were required to reimburse health care home staff that performed care coordination for publically funded insurance beneficiaries.

Initiative Title: Lakewood Health System Health Care Home
Start Date: 2008
Practices: 1
Physicians: 15
Covered Lives: 700

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Implementation

UCare first began to partner with primary care practices during their involvement in a pilot program for dual-eligible seniors, the Minnesota Senior Health Options (MSHO) program.

MSHO is a dual-eligible fully integrated special needs plan that Minnesota has offered since 1997 — first as a demonstration, and then as a standard product. Besides Medicare and Medicaid services, MSHO includes home- and community-based waiver services for nursing-home-certifiable community dual-eligibles. The plan is administered by the Minnesota Department of Human Services and nine health maintenance organizations, including UCare, which has been a participant since the program was initiated.

Patient Story: Care Coordination

Patients with chronic illness, like Jody K., benefit from personal contact with a care coordinator.

When Jody K. of Bertha, Minn., (left) was diagnosed with multiple sclerosis, her life became dominated by medical visits, phone calls to doctors and constant attention to managing her twenty medications.

When she began seeing physicians at Lakewood Health System, Jody's doctor suggested she become a participant in Lakewood's Medical Home program. "I had no idea what that meant exactly," said Jody. "When my doctor explained what it was about, I was excited — but afraid to be too hopeful because I'd been through so much just trying to find someone who could help me feel better."

To start, Jody was given the name and number of Niki Worden, a registered nurse at Lakewood who would become Jody's care coordinator and her first point of contact whenever she had questions or was experiencing symptoms that were of concern. For Jody, that one act alone was transformative.

"With MS you can suddenly start having new symptoms or problems that you're not sure are because of your MS or something else," said Jody. "People with MS also have weakened immune systems, so I get sick a lot more than most people." Because of this, Jody used to make frequent phones calls to her doctor. Each time, she would find herself having to repeat her medical history and give more detail about all her medications and the issues she was experiencing. "I often needed to be seen fairly quickly, so having to tell my story over and over again was really frustrating."

That ended when Niki entered the picture. Whenever Jody was experiencing a flare-up with her MS or had a question about her medication, she picked up the phone and called Niki, who was familiar with Jody's medical history and had direct access to her medical records. If Jody needed to be seen right away, Niki would arrange a same-day appointment with Jody's personal physician.

As a result of her participation in the Lakewood Health System medical home, with help from her care coordinator Niki, Jody was able to reduce her medications by more than half and improve her quality of life. Her overall symptoms were eventually so well improved that she received a call from Niki wondering if everything was ok. "I hadn't called or been in for a while so Niki wanted to check in on me," said Jody. "I had to laugh because I told her I was doing really well, that's why she hadn't heard from me."

Jody can't imagine going back to the old way of receiving care. In September of 2010, she experienced some unexpected issues that resulted in an emergency room visit, something that hadn't happened in some time. "Because all my care is coordinated, Niki knew about my ER visit," said Jody. "She immediately got involved to make sure I understood my follow-up instructions and that my doctor was aware of the visit. Knowing I have someone I can call who knows me and my medical history has taken so much of the anxiety out of having a chronic illness. As for Niki and the other Medical Home staff, well, I call them my angels."

UCare currently reimburses state-recognized health care homes for care coordination services that are provided to recipients of state-funded insurance and their dually eligible MSHO population. In order to reduce costs and improve outcomes, UCare ensures that health care is accessible and coordinated across preventive, primary, acute, post-acute, rehabilitation and long-term care; for example, care coordinators train practice staff and support them with decision-making processes for members. UCare also provides care coordinators employed by partner practices with care management software that includes risk stratification capabilities, and conducts joint trainings.

UCare views its role as not only tracking enrollment and paying for care, but also coordinating care across systems to ensure that there is continuity of care and other medical services. To this end, the plan engages members back with their primary care clinics and physicians to ensure the systematic delivery of care.

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The health plan partners with health care homes like Lakewood Health System by coordinating payment structures, supplementing their care coordination and training them to offer "the broadest array of coverage,"[1] including managing home-delivered meal services, transportation, chore services and home-nursing care, among other services. Lakewood had been having difficulties finding payers who were willing to reimburse for the care coordination work, and UCare was willing to do so across all its products, including Medicare, Medicaid and dual-eligibles.

UCare also formed a relationship with Lakewood to measure outcomes that the clinic had not been able to quantify on its own, such as admissions, readmissions and emergency room claims. The plan analyzed these utilization measures as well as cost of care, and then shared data with Lakewood to determine the impact of the medical home intervention on patients. It provided the clinic with data from the Physician's Quality Reporting Initiative, a Centers for Medicare & Medicaid Services-implemented program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals.[2]

UCare also works with several clinics to monitor total cost of care outcomes and population health.

Sustainability

UCare has applied the lessons it learned in its MSHO product to other populations, including Medicare and Medicaid members. For example, UCare worked with Bluestone Physician Services — a "clinic without walls" which brings physicians and nurse practitioners to nursing homes and assisted living locations — to improve its care coordination capacity. Due to the success UCare saw in its arrangement with Bluestone and Lakewood, the plan broadened its work to include all of its products.

By expanding its scope of medical home activities and increasing the data collected, UCare was able to determine if outcomes changed in a statistically significant way. With only a single product in a small rural area — where, for example, UCare may have only had 20 patients in a particular nursing home — it was difficult to measure outcomes. By expanding to all products, it expanded the population served to 700, which allowed the plan to conduct more accurate data analysis. At the same time, the relatively stable, rural population provided a good base for analysis.

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Outcomes

Outcome measures reported by UCare for the Lakewood Health System pilot were limited to Medicare, Medicaid and Medicare/Medicaid dually eligible patients. For those patients, the health plan reported a 37 percent decrease in the total cost of care and an 18 percent decrease in inpatient admissions for members in the program.

Outcomes being studied include adherence to Physician Quality Reporting Initiative, National Committee for Quality Assurance, patient satisfaction (CAHPS®) and Bridges to Excellence measures. UCare is also monitoring its performance in the Medicare Five-Star Quality Rating System. Other notable measures include emergency department utilization and total cost of care trends.

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Scale

Because of its experience, UCare has been able to complement existing care coordination programs as the number of newly accredited health care homes increases throughout the state. In the future, as the health plan's enrollment increases, UCare hopes to partner with practices and move into partial and full-risk reimbursement models.

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[1] Participant interview with Rebecca Malouin, Ph.D., 2011

[2] "Physician Quality Reporting System." *Centers for Medicare & Medicaid Services*. Available <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html>

A copy of the full ACHP report on strengthening primary care for patients, supplementary profiles on member plan initiatives, a one-page fact sheet and other resources are available online at www.achp.org or by emailing innovations@achp.org.