Coordination of Care Reference Guide

UnitedHealthcare Community Plan of Iowa* offers integrated, patient-centered care that we customize for each member's health care needs. Our case managers work closely with members and their primary care physicians (PCP), along with the other specialists and caregivers involved with their care, for a coordinated approach that helps ensure the best possible health outcomes. Your patients who are UnitedHealthcare Community Plan of Iowa members who receive long-term services and support (LTSS) are assigned a dedicated community-based case manager to help coordinate all aspects of their health care, including behavioral health and LTSS providers who deliver home- and community-based services (HCBS).

Please refer to this guide for information about coordination of care for your patients who are UnitedHealthcare Community Plan members. If you have questions, please call Provider Services at 888-650-3462. Thank you.

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Primary Care Physician Model of Care

As part of our Primary Care Physician (PCP) model of care, all members select or are assigned a PCP who coordinates their care and makes referrals to specialists and ancillary care providers as necessary. We update your panel of assigned members monthly on UnitedHealthcareOnline.com > Link. As a PCP, you are responsible for providing care coverage 24 hours a day, seven days a week and arranging back-up coverage when not available.

PCP Model of Care Performance Targets

As part of the PCP model of care, we establish performance targets for network PCPs based on the National Committee for Quality Assurance's Healthcare Effectiveness Date and Information Set (HEDIS) measures. To help you meet these performance targets, our online care coordination tool, CommunityCare, highlights potential gaps in care according to the HEDIS measures. This information may help you identify and close gaps in care to achieve your performance targets.

Our PCP Model of Care follows Iowa's EPSDT *Care for Kids* program

Iowa's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Care for Kids program for Medicaid members younger than 21 emphasizes the use of a regular schedule of recommended well-child health visits, called screenings, to provide preventive health care and identify medical, developmental and social-emotional concerns. The EPSDT program requires that Medicaid pay for any medically necessary diagnostic and treatment services for problems that are detected as part of a well-child screening exam. For more information, visit www.iowaepsdt.org.

Patient-centered Planning Process

Patient-centered planning includes a care service team centered around the member or member representative, including the PCP, other care providers involved in the member's care and an assigned community-based case manager. Specialists and long-term services and support providers work with PCPs and case managers to coordinate care

Role of the Care Service Team

The care service team assesses the member's need for services, taking into consideration the member's preferences and availability of services and:

- Actively engages the member and encourages their participation in their care plan
- Takes into account and makes accommodations for the member's language and cultural background
- Continually monitors and updates the care plan as the member's needs change, based on request or at least annually

Role of the Case Manager

Members with chronic medical conditions are assigned a community-based case manager to help develop a patient-centered care plan that includes options for a full range of medical, behavioral, social/environmental and long-term services and support services. The case manager helps:

- Identify needs

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- Develop a care plan
- Ensure access to care
- Personalize care to the member's individual requirements and preferences
- Coordinate services

Role of Specialists and Long-Term Services and Support Providers
Specialists and long-term services and support providers need to have the member or member representative sign a consent form to share information before providing services and should report any change in a member's condition or circumstances to the case manager.

CommunityCare Online Planning Tool

As part of the patient-centered planning process, we use an online planning tool called CommunityCare to coordinate care, identify potential gaps in care and provide a central location for the following information:

- Risk needs assessment
- Care plan
- Medication list
- Personalized emergency plan
- Biometric measures and lab tests

You may access CommunityCare at UnitedHealthcareOnline.com > Link.

Health Homes, Integrated Health Homes and Accountable Care Communities

If you were contracted as a Health Home or Accountable Care Community, please review the following overview of these coordinated approaches to care. For more information, go to UHCCommunityPlan.com > For Health Care Professionals > Iowa > Provider Administrative Provider Manual. Additional information regarding the Health Home program can be found on the Iowa Department of Human Services website at dhs.iowa.gov > Provider Services > Provider Enrollment > Enrolling as an Iowa Medicaid Provider in the Health Home Program. For Integrated Health Homes, additional resources can be found on the Iowa Department of Human Services website at dhs.iowa.gov > Provider Services > Integrated Health Homes.

Health Homes Model

The health home model, as defined in Section 2703 of the Affordable Care Act, offers coordinated care to individuals with multiple chronic health conditions, including mental health and substance use disorders. This model is a team-based clinical approach that includes the consumer, his or her providers, and family members, when appropriate. The health home model builds linkages to community supports and resources as well as enhances coordination and integration of primary and behavioral health care to better meet the needs of people with multiple chronic illnesses. This coordinated care is provided through the delivery of the following six core services:

- Comprehensive care management
- Care coordination
- Services that promote improvements in health
- Comprehensive transitional follow-up care
- Member and family support services
- Referral to community and social support services

There are two health homes programs available:

- Health Homes—primary focus on members with multiple chronic medical conditions
- Integrated Health Homes—primary focus on members with serious and persistent mental illness (SPMI)

Health Homes

- Adults and children may qualify for the Health Homes program if they have two or more of the following chronic conditions or have one chronic condition and are at risk of developing a second:
  - Mental health condition
  - Substance abuse disorder
  - Asthma
  - Diabetes
  - Heart disease
  - Hypertension
  - Overweight
    - BMI over 25
    - BMI over 85 percentile for pediatric population

Integrated Health Homes

The goal of the Integrated Health Homes program is to develop a team of health care professionals to integrated medical, social, and behavioral health care needs for individuals with serious mental illness (SMI) or serious emotional disturbance (SED).

Adults and children may qualify for the Integrated Health Homes program if they have a SMI or SED. SMI is defined as:

- Psychotic disorders
- Schizophrenia
- Schizoaffective disorder
- Major depression
- Bipolar disorder
- Delusional disorder
- Obsessive-compulsive disorder

SED is a diagnosable mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria specified within the most current Diagnostic and Statistical Manual of mental

disorders published by the American Psychiatric Association or its most recent International Classification of Diseases equivalent that result in functional impairment. SED may co-occur with substance use disorders, learning disorders, or intellectual disorders that may be a focus of clinical attention.

Accountable Care Communities

Accountable Care Communities (ACCs) are collaborative partnerships with hospitals and clinics across the continuum of care and are effectively a Medicaid Accountable Care Organization (ACO). We aim to create stronger systems of care within each practice clinical team and their population by delivering information, processes and support to enable the clinical leaders to proactively manage at the population level within the practice. This includes identifying risk and managing access to care to ensure there is availability to meet the needs for preventive care and chronic care coordination. We provide practices and communities with technology, process improvement and analytics, clinical support and tools to enhance the way care is delivered.

Behavioral Health Guidelines

As part of our holistic approach to care, our case managers screen all new members for physical and behavioral health related conditions and social/environmental concerns to identify members who may need behavioral health care services. Our behavioral health guidelines recommend encouraging members to:

- Evaluate options and choose their behavioral health specialist as appropriate
- Be involved, along with their caregivers, in decisions about services
- Maintain their home environment, education and employment
- Develop and maintain a stable and safe family environment for children and their families

To help you identify members with behavioral health needs, see the PCP Behavioral Health Toolkit at UHCCommunityPlan.com > For Health Care Professionals > Iowa > Billing and Reference Guides.

Principles of Recovery-Based Services

Recovery-based services are grounded in the belief that recovery is possible and:

- Promote member involvement and decision-making
- Empower and encourage members to have a meaningful, productive role in society
- Help reduce stigma and discrimination against members

Keeping Members with Mental Health Illness in the Community

The 1915(c) Children's Mental Health Waiver may allow members who are identified as requiring a psychiatric hospital level of care to remain in the community with the help of the following long-term services and supports. If there is a waiting list for this waiver, the member may choose to receive other support services.

- Environmental modifications, adaptive devices and therapeutic resources
- Family and community support services
- In-home family therapy

- Respite care

Providing HCBS for Members with Chronic Mental Illness

The 1915 (i) Habilitation Services for Members with Chronic Mental Illness Waiver provides home and community-based services for members with chronic mental illnesses. Habilitation Services are designed to assist members in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home- and community-based settings. Services available include:

- Home-based habilitation
    - Adaptive skill development
    - Assistance with activities of daily living
    - Community inclusion
    - Transportation
    - Adult educational supports
    - Social and leisure skill development
    - Personal care
    - Protective oversight and supervision
- Day Habilitation
- Prevocational Habilitation
- Supported Employment Habilitation

Services for Children with Serious Behavioral Health Conditions

Our comprehensive treatment approach includes covered services for members with behavioral health issues, such as phone consultations with a child psychiatry team, emergency stabilization response to crisis situations, on-site mental health counseling, follow-up with the child's family, peer support, identification and connection to community resources and referral to community mental health agencies. This comprehensive treatment approach includes:

- Community support to help stabilize a child's behavioral health symptoms as part of discharge planning
- Crisis planning to help identify triggers and interventions to reduce the risk of future crises and offer supports and interventions
- Certified peer specialists to offer phone counseling and help establish recovery groups to help members learn coping skills

HCBS Waivers, Long-term Services and Support and Nursing Facility Long-term Care Admission

Medicaid home- and community-based services (HCBS) are federally approved waiver programs. Individuals must have a need for assistance with activities of daily living or need assistance due to their inability to function independently in their home- or community-related to their disability or age. If eligible, the member is offered long-term services and support (LTSS) by our contracted agencies as part of their care plan. The following chart lists LTSS available through HCBS waivers. While these services are provided, case managers stay in contact with members to make sure their needs are met and they are able to comply with their treatment plan.

Long-Term Services and Support available through HCBS Waivers

Available Service	Type of Waiver						
	AIDS/ HIV	Brain Injury	Children's Mental Health	Elderly	Health and Disability	Intellectual Disability	Physical Disability
Adult day care; half day	X	X		X	X	X	
Adult day care; full day	X	X		X	X	X	
Adult day care; extended day	X	X		X	X	X	
Adult day care; hourly	X	X		X	X	X	
Assisted living services				X			
Assistive devices per item				X			
Behavioral programming (i.e., health and behavioral intervention); 15 minute unit		X					
Behavioral programming (i.e., mental health plan development); 15 minute unit		X					
Behavioral programming (mental health assessment); 15 minute unit		X					
CDAC (agency); 15 minute unit	X	X		X	X	X	X
CDAC (individual); 15 minute unit	X	X		X	X	X	X
Chore; 15 minute unit				X			

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Counseling (individual); 15 minute unit	X				X		
Counseling (group); 15 minute unit	X				X		
Day habilitation; per day						X	
Day habilitation; 15 minute unit						X	
Environmental modifications and adaptive devices (home modification); per item			X				
Environmental modifications and adaptive devices (personal care items); per item			X				
Environmental modifications and adaptive devices (specialized supply); per item			X				
Family and community support; 15 minute unit			X				
Family counseling and training; 15 minute unit		X					
Financial management services; per month	X	X		X	X	X	X
Home-delivered morning meals; per meal	X			X	X		
Home-delivered liquid supplemental meal; two cans per meal	X			X	X		
Home-delivered noon meals: per meal	X			X	X		
Home-delivered evening meals; per meal	X			X	X		
Home health aide; 15 minute unit	X			X	X	X	
Homemaker; 15 minute unit	X			X	X		
Home and vehicle modification (home modifications only); per service		X		X	X	X	X
Home and vehicle modification (vehicle modifications only);		X		X	X	X	X

per service							
IMMT (HH agency home health aide); 15 minute unit		X				X	X
IMMT (HH agency RN); 15 minute unit		X				X	X
IMMT (HH agency LPN); 15 minute unit		X				X	X
IMMT (SCL; 15 minute unit		X				X	X
IMMT (group); 15 minute unit		X					
In-home family therapy; 15 minute unit			X				
Mental health outreach; 15 minute unit				X			
Nursing (RN); 15 minute unit	X			X	X	X	
Nursing (LPN); 15 minute unit	X			X	X	X	
Nutritional counseling (initial); 15 minute unit				X	X		
Nutritional counseling (subsequent); 15 minute unit				X	X		
Personal emergency response (initial fee for install)		X		X	X	X	X
Personal emergency response (monthly)		X		X	X	X	X
Prevocational services (daily)		X				X	
Prevocational services; per hour		X				X	
Respite (HH agency, specialized); 15 minute unit	X	X	X	X	X	X	
Respite (HH agency, basic individual); 15 minute unit	X	X	X	X	X	X	
Respite (HH agency group); 15 minute unit	X	X	X	X	X	X	
Respite (home/non-facility, specialized); 15 minute unit	X	X	X	X	X	X	
Respite (home/non-facility basic individual);	X	X	X	X	X	X	

15 minute unit							
Respite (home non-facility, group); 15 minute unit	X	X	X	X	X	X	
Respite (hospital or NF) • RCF • Adult day care • Child care facility • ICF/ID • Foster group care 15 minute unit	X	X	X	X	X	X	
Respite (resident camp); 15 minute unit	X	X	X	X	X	X	
Respite (group day camp)	X	X	X	X	X	X	
Senior companion; 15 minute unit				X			
Specialized medical equipment; per item		X					X
Supported community living; daily		X				X	
Supported community living; 15 minute unit		X				X	
Supported community living (residential-based); daily						X	
Supported employment (job development)		X				X	
Supported employment (employer development		X				X	
Supported employment (enhanced job search); 15 minute unit		X				X	
Supported employment (job coaching); 15 minute unit		X				X	
Supported employment (enclave); 15 minute unit		X				X	
Transportation; per mile; individual		X		X		X	X
Transportation; per mile; group		X		X		X	X
Transportation; 1-way trip; individual		X		X		X	X

Transportation; 1-way trip; group		X		X		X	X
Transportation; non-emergent wheelchair van; individual; trip		X		X		X	X
Transportation; non-emergent wheelchair van; group; trip		X		X		X	X
Transportation; non-emergent ; escort; trip		X		X		X	X
Workman's compensation	X	X		X	X	X	X
Financial Management Service (FMS)	X	X		X	X	X	X

Nursing Facility Long-term Care Admission

We use the federal Preadmission Screening and Resident Review process to help ensure that members are not inappropriately placed in nursing homes for long-term care. If a member is admitted to a nursing facility for long-term care, their assigned case manager will remain involved in their care planning and continue to monitor them in the nursing facility to re-assess them for possible return to community living with LTSS.

If you have questions about coordination of care for your patients who are UnitedHealthcare Community Plan members, please call Provider Services at 888-650-3462. Thank you!