Itasca Medical Care, H2417
Dual Eligible (Medicare Zero-Cost-sharing) Special Needs Plan

Model of Care Score: 77.50%
2-Year Approval **January 1, 2014 – December 31, 2015**

Target Population

This SNPs target population contains members who have a Low Income Subsidy Designation. Itasca Medical Care's (IMCare) Dual–Eligible SNP program is also known as Minnesota Senior Health Options (MSHO), under the Minnesota Department of Human Services. The general enrollment criteria for this plan are those who are Sixty-five (65) years of age or older or turning sixty-five (65) years of age within the month they are requesting enrollment and are eligible for Medical Assistance and Medicare Parts A and B as well as being eligible to enroll in Minnesota Senior Care+ within Itasca County's service area – a Medicaid eligibility designation. IMCare also has its own parameters for qualification, including those living in a nursing facility.

Provider Network

IMCare's provider network has providers from various disciplines such as primary and specialty medical care, mental health services, dental providers, long-term care facilities, ophthalmologists, chiropractic, therapies, pharmacy, specialty care and other ancillary services, audiology and hearing providers, home care providers, and elderly waiver service providers

Care Management and Coordination

Health risk assessments (HRAs) are completed by care/case coordinators who call all new enrollees age 65 and older within 30 days of enrollment and then annually thereafter. The annual reassessment is usually performed face to face. The assessment is utilized to identify members who may require referrals to public health, a disease management program and/or care/case management follow-up. The responses obtained from the HRA are then entered into the Minnesota State enrollment system and IMCare's system. The HRA addresses the member's health status, including condition-specific issues, documentation of clinical history including medications, activities of daily living, mental health and cognitive function status, life-planning activities, cultural and linguistic needs, preferences or limitations, visual and hearing needs and evaluation of caregiver resources and involvement.

IMCare's case management program includes the development of an individualized comprehensive plan of care (ICP) with a focus on promoting and ensuring service accessibility, attention to individual needs, advance directives, prevention, continuity and coordination of care with key interdisciplinary providers of care or services, and fiscal and professional

accountability. A designated IMCare case manager/care coordinator has lead responsibility for creating, implementing and monitoring a member's care plan in conjunction with key stakeholders. Care plans are documented and maintained in IMCare's system, which can be readily accessed by quality improvement, care coordination and utilization management staff. The care plan will include things such as the identified needs and objectives, short and long term goals, timeframes for achieving goals, case management discharge criteria, frequency of monitoring the care plan through contacts with the member, provider, facility, family/caregiver and others as deemed necessary and authorized by the member.

Upon enrollment, each member is required to choose a primary care clinic (PCC) who acts as the member's gatekeeper. The interdisciplinary care team (ICT) membership is a collaborative effort between the member's provider(s), IMCare's QI/UM Nurse, IMCare QI mental health coordinator, allied health and social services providers and disease management coordinators as deemed necessary by the needs of the member. The ICT is responsible for working directly with the member and the member's primary care provider and other members of the care team to develop and implement a comprehensive plan of care. Care plans and progress towards the achievement of specific goals incorporated into the care plan are accessible via IMCare's tracking system.

This MOC summary is intended to provide a broad overview of the SNP's MOC. Although the full extent of any MOC cannot be conveyed in a short summary, this summary provides the reader with a general overview of how the SNP addresses beneficiary needs.

For more information about this health plan refer to the Special Needs Plan's website at: www.imcare.org.