Medica Health Care, H2458
Dual Eligible (Dual Eligible Subset-Medicare Zero Cost-sharing) Special Needs Plan

Model of Care Score: 85.63%
3-Year Approval **January 1, 2012 – December 31, 2014**

Target Population

Medica Dual Solution (MSHO) product is a fully integrated dual benefit plan. Individuals covered are those who have Medicare and Medicaid benefits and are 65 years of age and older. These members must identify with a primary care provider (PCP) upon enrollment as this allows for care coordination providers to be determined to work directly with members.

Provider Network

The provider network heavily utilizes geriatricians and internal medicine practitioners with a geriatric focus. Members in general, access care from internal medicine, gerontology, cardiology, orthopedics, ophthalmology, oncology, rheumatology, and infectious disease. Throughout Minnesota, most physicians accept members under Medica. The network also provides good access to services such as lab, physical therapy, occupational therapy, and rehabilitation.

Care Management and Coordination

Medica Healthcare Plans has designed a comprehensive health risk assessment (HRA) tool that was designated by the Minnesota Department of Human Services called the Long Term Care Screening Tool. The evidence-based tool incorporates a mental status evaluation and the depression screen; traditional activities of daily living (ADL), and independent activities of daily living (IADL) questions are also included. Assessments are performed on a face-to-face basis and completed within 30 days of enrollment. Reassessments are required annually thereafter. If a member's health status changes, a reassessment may be needed at that time as well. The care coordinator, a licensed nurse or social worker carries the primary responsibility while collaborating with the usual care practitioner. One of the care coordinator's accountabilities is coordinating communication regarding the HRA, stratification results, and benefits.

The care coordinator has the primary accountability for developing the plan of care (ICP). The annual face-to-face assessments with members ensure member/responsible party input and participation. The care coordinator considers the risks identified during the assessment, the member/family wishes, and ongoing conversations or information received from involved practitioners or service providers when creating the plan of care and service plan. Medica's care plan requirements include: documenting each identified risk as an issue, determining short and/or long term goals for each risk, identifying measureable interventions, and evaluating the effectiveness of the intervention. The evidenced based assessment identifies potential risks related to falls, cognitive deficits, self-care concerns, depression, medication management, isolation and several other factors. The care coordinator then identifies interventions and services

that address these vulnerabilities as many result in increased risk to seniors. Medica monitors outcome measures via annual care plan audits.

Interdisciplinary teams (ICT) consist at a minimum of the member and/or his representative, the care coordinator and the PCP. Team members are added based on identified by the specific physical, emotional, and service needs of the member. Within a care system, the care coordinator and their affiliated clinicians may serve as the ICT. In an institutional setting, the member is assessed during a face-to-face visit and the needs and wishes of the member are initiated during this assessment. Unless the member is incapable or refuses to participate, Medica's policy is to include the member in the ICT. When members are incapacitated, attempts are made to include the responsible party in the ICT. As the care coordinator learns of other involved or needed specialists, s/he communicates with them about the member's needs. As most care coordination providers operate within a care system of PCPs, specialists, home health providers and care coordinators, the appropriate care coordinator may accompany the member to an office visit. Electronic medical records in the integrated care systems are used to communicate and document care decisions. The frequency of meetings and communications are based upon the fragility of the member, the higher the risk the more frequently the team communicates.

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 member needs.

For more information about this health plan refer to the Special Needs Plan's website at: https://www.medica.com/find-plans/medicare-plan-options/plan-group-2014/medica-dual-solution/minnesota-senior-health-options